

Promise and Pitfalls of Dual Eligible Special Needs Plans (D-SNPs)



Like other Medicare enrollees, people who are dually eligible for Medicare and Medicaid can choose to receive their Part A and Part B benefits through Original Medicare (OM) or from a private Medicare Advantage (MA) plan. Some who select MA may have access to a Dual Eligible Special Needs Plan (D-SNP)ⁱ which is an MA plan exclusive to people enrolled in both programs. Below we examine D-SNPs' potential to improve integrated care and the beneficiary experience.

Dually Eligible Enrollees

Over 12.5 million people are eligible for both Medicare and Medicaid.ⁱⁱ Over 70% receive the full suite of Medicaid benefits,ⁱⁱⁱ while the remainder qualify for help with their Medicare costs through the Medicare Savings Programs.^{iv}

For fully dually eligible individuals, also called "full duals," Medicare is their primary insurer and mainly pays for medical services, such as hospital care, doctors' visits, home health care, hospice, and prescription drugs. Medicaid wraps around this coverage, often helping with Medicare costs^v and paying for services that OM does not, such as long-term care, including home and community-based services, as well as some dental, hearing, vision, and behavioral health services. Although some MA plans may offer these benefits, that coverage is typically limited.^{vi}

Definitionally, all dually eligible individuals have low incomes; 87% live on less than \$20,000 a year.^{vii} More than half are people of color, compared with 20% of Medicare beneficiaries without Medicaid.^{viii} They have disproportionate health challenges: Over 40% of dually eligible beneficiaries report being in fair or poor health, compared to 17% of those with Medicare only, and around 26% have five or more chronic conditions, compared to 15% of non-dual Medicare enrollees.^{ix} They also account for relatively large portions of program expenditures. In 2020, dually eligible enrollees comprised 17% of the Medicare population and 33% of total spending; they similarly accounted for 14% of all Medicaid enrollees and 32% of Medicaid spending.^x

MA enrollment has increased overall in recent years, including among those dually eligible for Medicare and Medicaid. The share of dually eligible OM enrollees declined by 7.7% between 2018 and 2020, while their participation in MA grew by 8.6%. Medicare-Medicaid enrollees are now more likely to have an MA plan than their non-dual counterparts (41% vs. 35%).^{xi}

Medicare and Medicaid

Dually eligible individuals have diverse needs and circumstances, but nearly all face challenges navigating their coverage. Being enrolled in Medicare and Medicaid can mean working with two sets of benefits, rules, processes, and providers. They often face specific barriers regarding the programs' lack of **care management**, **benefits integration**, and **integrated appeals and grievances**.

- **Care Management:** Most providers in the country accept Medicare, but Medicaid providers are less ubiquitous. Consequently, dually eligible individuals' provider networks rarely align. This disconnect, coupled with their high care needs and corresponding utilization rates, intensifies the likelihood of miscommunication across providers, leading to problems like repeated tests, prescribed drugs that interact with each other, redundant office visits, and inadequate follow-up care after hospitalization or surgery.^{xii} By increasing duplicative care and reducing the effectiveness of treatments, this lack of coordination can burden enrollees, providers, and the programs—driving up costs, creating administrative hurdles, and worsening outcomes. There is a solution: Effective care management could organize and track a person's care across multiple programs and providers. If done holistically, such an approach could also address other critical needs, like transportation and housing.
- **Benefits Integration:** Because Medicare and Medicaid cover different services and pay different amounts at different times, beneficiaries might not know which program handles specific aspects of their care. This confusion can extend well beyond enrollees. State Medicaid representatives might not understand interactions with Medicare, while Medicare providers or MA plans may not know what is available through Medicaid. This can and does lead to problems. For example, we have seen states require an enrollee to get a denial from Medicare before Medicaid will cover a service, even if the service has never been available through Medicare and no formal denial process exists or should be necessary. Integrating benefits could minimize these scenarios by allowing a dually eligible individual to get all their care through one entity.
- **Integrated Appeals and Grievances:** Similarly, when enrollees need to appeal a coverage decision, they may not know whether to turn to Medicare or Medicaid, or what the relevant timelines and processes might be. Medicare's appeals system alone can be a significant barrier to care. It is confusing, daunting, and time-consuming, and as a result, rarely used. A recent report found that only 1% of MA denials were

appealed, suggesting many enrollees abandon needed services or pay for them out-of-pocket, possibly undermining their health and financial security.^{xiii} Even those who successfully appeal are not left unscathed; they too experience care delays that may worsen outcomes. Layering in distinctly complicated Medicaid appeal rules only compounds these problems and heightens the need for an integrated appeals and grievances system. Enrollees must know where to go for help.

The Potential of D-SNPs

D-SNPs offer a unique framework to address these coordination and integration issues. As with all MA plans, they must cover Medicare Part A and Part B benefits. They are additionally required to include Part D prescription drug coverage other MA plans can omit and are subject to special rules for integrating Medicare and Medicaid.^{xiv} In states where D-SNPs are available, only individuals eligible for full Medicaid and, in some instances, for a Medicare Savings Program, may participate. As of February 2022, D-SNPs in 45 states and D.C. were serving nearly four million enrollees.^{xv}

- **Care Management:** All D-SNPs are required to establish a Model of Care (MOC) that explains how the plan will identify and address the needs of each enrollee.^{xvi} For example, the MOC might require the plan to develop interdisciplinary care teams, arrange specific health exams, coordinate care across different providers, or create individual care plans for enrollees.^{xvii} It might also reference a “case manager” or “care coordinator.” Individuals in these roles are typically responsible for ensuring the pieces fit together properly, such as by overseeing communications between providers and, in some cases, between enrollees and care teams. Ideally, all MOC-outlined care plans and treatments are person-centered and reflect the enrollee's preferences.
- **Benefits Integration:** At their most integrated, D-SNPs can seamlessly cover the full suite of Medicare and Medicaid services, allowing enrollees to interact with one plan and one set of coverage rules. In recent years, Congress and the Centers for Medicare & Medicaid Services (CMS) have taken steps to move plans in this direction. Since 2021, federal regulations implementing the Bipartisan Budget Act (BBA) of 2018 have required D-SNPs to meet new minimum integration standards, including by coordinating long-term services and supports (LTSS) and behavioral health care in some situations.^{xviii}
- **Integrated Appeals and Grievances:** D-SNPs can also integrate appeals and grievance processes, at least at the plan level, to establish a no-wrong-door approach and a single set of appeals procedures. Some plan types currently do so; the rules implementing the BBA of 2018 also advanced this goal.^{xix}

Opportunities for Improvement

Critically, not all D-SNPs are created equal. There are several plan types with different levels of integration.^{xx} Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) must cover primary and acute care, plus some LTSS and behavioral health benefits, if not carved out by the state. Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) must also cover primary and acute care and can choose to offer behavioral health or LTSS. The third plan type, “coordination only” D-SNPs, integrate benefits solely by notifying the state when a full dual is admitted to a hospital or skilled nursing facility. D-SNP look-alikes, MA plans crafted to resemble D-SNPs to lure dually eligible enrollees without providing any extra benefits or coordination, create further complexity.

These nuances are confusing enough, but they exist within an increasingly cluttered MA landscape. In 2023, enrollees had access to 43 MA plans, on average, more than twice as many as in 2018.^{xxi} Fundamentally, the ever-growing number of MA plans and the variances across each can hinder sound analysis and decision-making.^{xxii} Beneficiaries may become overwhelmed and select or continue with a plan that does not meet their needs or correspond with their preferences. This may be especially true for dually eligible enrollees, who face additional barriers—although more MA plans are available overall, highly integrated D-SNPs remain elusive. In 2022, under 10% of all D-SNPs were FIDE-SNPs, 30% were HIDE SNPs, and the remaining 61% were “coordination only.”^{xxiii}

Enrollment difficulties, inadequate decision-making supports, and the relative paucity of meaningfully integrated plans can limit enrollee engagement, plan accountability, and coverage efficacy. Indeed, in our experience, many are unaware they are even enrolled in a D-SNP. This could indicate the plans are working perfectly to seamlessly integrate care, but it is more likely that enrollees are making sub-optimal coverage choices and that plans are under-delivering on promised integration, generally providing coverage that is indistinguishable from standard MA plans. As a result, D-SNP enrollees may neither expect nor see any differences from other Medicare-Medicaid coverage arrangements.

While D-SNPs hold significant promise, improvements are needed to better **support enrollees and simplify plan choice, strengthen D-SNP performance and accountability, and encourage state integration efforts.**

- **Support Enrollees and Simplify Plan Choice:** As dually eligible people seek to enroll in an MA plan, they can quickly become overwhelmed by their options and confused by marketing that heavily promotes supplemental benefits they may already have access to through Medicaid. Those who turn to Medicare’s primary decision-making tool, Medicare Plan Finder, may not get the help they need. While Plan Finder includes D-

SNPs in the search results if people say they have Medicaid coverage, the plans are easy to overlook and do not include actionable information about Medicaid benefits.

- **Strengthen D-SNP Performance and Accountability:** Medicare-Medicaid disconnects create harmful gaps in communication and access for many enrollees. Despite MOCs and the promise of care management, D-SNP enrollees do not always see additional support or experience better coordination across programs and providers. While exclusively aligned enrollment would help, it is only required of FIDE SNPs, and not until 2025. Even when essential functions like appeals and grievances are somewhat integrated, it's at the plan level only and issues typically remain around navigation, backlogs, and carve-outs.^{xxiv}
- **Encourage State Integration Efforts:** D-SNPs have contracts at the federal and state levels. The federal rules set minimum integration requirements. While states can go beyond that baseline, only some have done so.^{xxv} This may be “due to limited state experience using managed care to provide Medicaid coverage to dually eligible beneficiaries, a lack of Medicare expertise, and competing priorities.”^{xxvi} The upshot is few D-SNPs are maximally integrated and state standards often vary, creating barriers to care and stakeholder confusion.

Discussion

The current system, where people with the highest needs have the fewest resources and the biggest hurdles to overcome, is unsustainable.

Although the promise and the reality of D-SNPs diverge, there are clear opportunities for improvement, including by better integrating Medicare and Medicaid and more clearly defining what integration does and should mean for the people enrolled in both programs.

ⁱ Centers for Medicare & Medicaid Services, “Dual Eligible Special Needs Plans (D-SNPs)” (last visited May 1, 2023), <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs>.

ⁱⁱ Maria Peña, *et al.*, “A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)” (January 31, 2023), <https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicicaid-enrollees-dual-eligibles/>.

ⁱⁱⁱ Centers for Medicare & Medicaid Services, “Dually Eligible Individuals – Categories” (last visited May 1, 2023), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf>.

^{iv} Medicare Interactive, “Medicare Savings Program basics” (last visited May 1, 2023), <https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-savings-programs-qmb-slimb-qi/medicare-savings-program-basics>.

^v Medicare Interactive, “How Medicaid works with Medicare” (last visited May 1, 2023), <https://www.medicareinteractive.org/get-answers/cost-saving-programs-for-people-with-medicare/medicare-and-medicicaid/how-medicicaid-works-with-medicare>.

^{vi} Meredith Freed, *et al.*, “Medicare and Dental Coverage: A Closer Look” (July 28, 2021), <https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/>.

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- vii MaryBeth Musumeci, *et al.*, “Medicaid Financial Eligibility in Pathways Based on Old Age or Disability in 2022: Findings from a 50-State Survey” (July 11, 2022), <https://www.kff.org/report-section/medicaid-financial-eligibility-in-pathways-based-on-old-age-or-disability-in-2022-findings-from-a-50-state-survey-appendix/> and Maria Peña, *et al.*, “A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)” (January 31, 2023), <https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicicaid-enrollees-dual-eligibles/>.
- viii Maria Peña, *et al.*, “A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)” (January 31, 2023), <https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicicaid-enrollees-dual-eligibles/>.
- ix *Id.*
- x The Medicaid and CHIP Payment and Access Commission and the Medicare Payment Advisory Commission, “Beneficiaries Dually Eligible for Medicare and Medicaid” (February 2023), https://www.medpac.gov/wp-content/uploads/2023/02/Feb23_MedPAC_MACPAC_DualsDataBook-WEB-508-SEC.pdf.
- xi *Id.*
- xii Sarah Barth, *et al.*, “Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches” (March 2019), <https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf>.
- xiii U.S. Department of Health and Human Services Office of Inspector General, “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials” (September 2018), <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>.
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- xviii Centers for Medicare & Medicaid Services, “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021” (April 16, 2019), <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>.
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- xxvi *Id.*