

A photograph of two women in conversation. The woman on the left is older, with short dark hair, wearing glasses and a blue patterned top. The woman on the right is younger, with long dark hair, wearing large hoop earrings and a dark top. They are both looking towards the right side of the frame. The background is slightly blurred, showing what appears to be an outdoor setting with a yellow canopy.

# JUSTICE IN AGING

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## ISSUE BRIEF

### Dual Eligible Special Needs Plans (D-SNPs): What Advocates Need to Know

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Almost three million individuals eligible for both Medicare and Medicaid (dual eligibles) are enrolled in Dual Eligible Special Needs Plans (D-SNPs) and that enrollment is expected to rapidly rise.<sup>1</sup> An increasing number of states are focusing on D-SNPs as a primary vehicle for integrating care and improving coordination of services for their dual eligible populations. Yet many advocates know little about what D-SNPs are, what makes them unique, and how they operate. This issue brief provides advocates with basic information about D-SNPs, whom they serve, and their structure. It also identifies specific areas where advocates can engage with their states to ensure that D-SNPs work effectively to coordinate care and benefits for dual eligibles, including strategies in centering equity from the outset in the design of D-SNPs.

## THE BASICS: WHAT ARE D-SNPS & WHOM DO THEY SERVE

Special Needs Plans (SNPs), a subset of plans within the Medicare Advantage program, were launched in 2006 to serve specific populations within Medicare managed care. There are three categories of SNPs: D-SNPs, which serve individuals who are dually eligible for Medicare and Medicaid, I-SNPs, which serve individuals who are in institutions or receiving long-term services and supports in the community; and C-SNPs, which serve individuals with specific chronic conditions.<sup>2</sup> SNPs first began operating under temporary authority and were made permanent in 2018.<sup>3</sup>

D-SNPs form the largest category of SNPs, both in enrollment and in number of plans offered.<sup>4</sup> D-SNP enrollment is growing rapidly. Currently more than a quarter of dual eligibles nationally are enrolled.<sup>5</sup> The number of D-SNPs

has skyrocketed from 172 plans nationwide in 2007 to 700 plans in 2022.<sup>6</sup> As of January 2021, D-SNPs operate in the District of Columbia and every state except Alaska, Illinois, New Hampshire, North Dakota, Vermont and Wyoming.<sup>7</sup> Although enrollment levels vary greatly by state and by region within states, 93% of dual eligibles live in a county where at least one D-SNP is available.<sup>8</sup>

Populations that have experienced systemic discrimination are disproportionately dually eligible. For example, **individuals who qualify for Medicare based on disability, people of color and women are more likely to be dual eligibles than those who qualify for Medicare based on age, who are male, and who are white.** See the Appendix for a snapshot of the characteristics of the dual eligible population.

## D-SNPS ARE SUBJECT TO BOTH FEDERAL AND STATE OVERSIGHT

As a subset of Medicare Advantage, D-SNPs are subject to federal oversight and must comply with Medicare Advantage regulations and guidance.<sup>9</sup> In addition, each D-SNP must develop an evidence-based Model of Care built around the characteristics of the population it serves and approved by the National Committee for Quality Assurance.<sup>10</sup>

D-SNPs are unique among Medicare Advantage plans because states also have a significant role in setting requirements and overseeing D-SNP performance. Each D-SNP sponsor must enter into a contract with the state in which the D-SNP operates.<sup>11</sup> Federal law sets out minimum requirements for these contracts, called State Medicaid Agency Contracts (SMACs). States can impose additional requirements regarding enrollee categories, details of how plans will manage care and benefit coordination with Medicaid, cost-sharing responsibilities of D-SNPs and other matters.<sup>12</sup>

### Advocacy Opportunities

Many state Medicaid agencies have limited in-house expertise in Medicare programs and policies, particularly as they affect dual eligible enrollees. With the significant growth in D-SNP enrollment and the urgent need to address health disparities among dual eligibles, it is increasingly important for states to develop such expertise, with dedicated personnel and/or a dedicated office to address the needs of dual eligibles and specifically to oversee SMAC contracts. Advocates can work to ensure that their state recognizes this need and devotes appropriate resources to dual eligible issues.

Advocates can also work with their state to formalize avenues for advocates and consumers to participate in the process of developing performance criteria in SMACs as well as review oversight mechanisms. It is particularly important to incorporate voices from marginalized communities, since an important role of D-SNPs should be to address longstanding health inequities among dual eligibles.

## STATES HAVE OPTIONS FOR IMPOSING ENROLLMENT RESTRICTIONS FOR D-SNPS

As with any Medicare Advantage plan, enrollment in a D-SNP is limited to individuals with both Medicare Part A and Part B coverage. Further, individuals must be dually eligible for both Medicare and Medicaid coverage. States

have the option of setting additional enrollment restrictions.

**Enrollment of Partial Duals.** States may allow enrollment of partial duals, that is, individuals who are only enrolled in a Medicare Savings Plan (QMB, SLMB or QI). Currently a majority of states (36) permit enrollment of partial duals.<sup>13</sup> States may limit enrollment to full-benefit dual eligibles or set even more restrictive enrollment criteria. For example, a state may authorize a D-SNP that only enrolls individuals who are full benefit dual eligibles and receiving long-term services and supports in the community, or a D-SNP that only enrolls dual eligibles who are receiving care in a skilled nursing facility.<sup>14</sup>

### Advocacy Opportunities

CMS and states are grappling with the question of whether to continue to permit D-SNPs to enroll individuals who only have Medicare Savings Program (MSP) coverage (partial dual eligibles) and do not have full Medicaid. Since these individuals are only receiving Medicare services and not entitled to any Medicaid services, it is questionable whether they derive any special benefit from D-SNP enrollment. This is an area that advocates can explore with their states and with D-SNP plan sponsors.

**Aligned Enrollment.** If a state delivers its Medicaid benefits through a Medicaid Managed Care Organization (MCO), the state may limit D-SNP contracts to plan sponsors that also operate an MCO in the same service area. This allows—but does not require—individuals to enroll in Medicare and Medicaid plans operated by the same sponsor (“aligned enrollment”). States may take a further step and require that a D-SNP limit enrollment to individuals who also are enrolled in a matching MCO (“exclusively aligned enrollment”).<sup>15</sup> D-SNPs with exclusively aligned enrollment may not have any members who are in an unaligned MCO or who are receiving their Medicaid benefits through fee-for-service Medicaid. Further, exclusively aligned D-SNPs may not enroll any members who are partial duals, since those members are not enrolled in any Medicaid MCO. Currently Idaho, Massachusetts, Minnesota, and New Hampshire have provisions in their SMACs that require exclusively aligned enrollment.<sup>16</sup>

### Advocacy Opportunities

The primary goal of the D-SNP model is better coordination of Medicare and Medicaid benefits. Currently, however, many dual eligibles are enrolled in a D-SNP operated by one plan sponsor and a Medicaid MCO operated by another plan sponsor. Such misaligned enrollment generally hampers rather than facilitates care coordination across programs. Since most states do not restrict this misaligned enrollment, advocacy about the issue can be important. One avenue of advocacy is to ensure that, if misalignment is permitted, there are measures in place requiring that the unaligned plans share information and work together to coordinate care. Another avenue is to seek provisions in SMAC contracts that increase alignment, such as the sample language developed by the ICRC.<sup>17</sup>

**Default Enrollment.** CMS permits default enrollment into a D-SNP when the individual is newly eligible for Medicare and in their initial enrollment period, and the individual is in a Medicaid MCO operated by the same sponsor as the D-SNP, and the state has approved the use of default enrollment.<sup>18</sup> Before default enrollment, the individual must receive prior notice of the default enrollment with an opportunity to opt out.<sup>19</sup> D-SNP members, like all dual eligibles, also have at least one opportunity per quarter in which to change plans or move to Original fee-for-service Medicare.

## Advocacy Opportunities

Experience with the dual eligible demonstrations has shown that, if default enrollment is implemented, very strong consumer protections, both before and after enrollment, are necessary to avoid disruptions in access to care. Written notices—at least two—to potential enrollees must be clear, simple, available in multiple languages and formats, and consumer-tested so individuals can understand what is happening and how to exercise their choices. Individuals should have easy access to explanations and options counseling and outreach should be culturally competent. Strong continuity of care provisions for out-of-network providers are necessary to prevent disruption in access after a default enrollment. Significant outreach to providers before the start of default enrollment also is a critical piece so that advice they give to their patients about enrollment choices is accurate and also because provider awareness is essential for care continuity protections to work.<sup>20</sup> For all of these preparatory steps, advocate input is essential.

## LEVELS OF INTEGRATION OF D-SNPS WITH MEDICAID CAN VARY MARKEDLY

The extent to which D-SNPs coordinate with Medicaid varies significantly. The most integrated plans are Fully-Integrated D-SNPs (FIDE-SNPs). FIDE-SNPs are single entities that hold capitated contracts to provide both Medicare and Medicaid services and whose contracts on the Medicaid side cover essentially all Medicaid services, including long-term services and supports and behavioral health services. HIDE-SNPs (Highly-Integrated D-SNPs) hold Medicare and Medicaid contracts but can do so either directly or through separate entities controlled by the same sponsor. To qualify as a HIDE-SNP, the sponsor's Medicaid contracts must cover provision of most Medicaid services, including long-term services and supports or behavioral health, but are not required to cover both.

### Examples

Mrs. Smith belongs to Best Health, a FIDE-SNP. She gets all her Medicare and Medicaid services from Best Health.

Mr. Lopez belongs to Better Health, a HIDE-SNP and also to Better Health MCO. He gets all his Medicare services through Better Health HIDE-SNP and most of his Medicaid services through Better Health MCO. However, in his state, Medicaid behavioral health services are “carved out” of Medicaid managed care and provided directly by the counties, so he does not get them from Better Health. Better Health helps him to get an appointment when he needs behavioral health but does not provide the service itself.

Note: D-SNPs are distinct from the fully capitated models tested by CMS in ten states in the Financial Alignment Initiative (often referred to as the duals demonstration).<sup>21</sup> In those models, a participating plan provides all Medicare and Medicaid services, receiving fully capitated payments from both CMS and the state. Those payments can be used together for all covered and supplemental services under both programs. With D-SNPs, even if they are FIDE-SNPs, the financing remains distinct and cannot be merged. Several states that participated in the Financial Alignment Initiative have decided to pull back from full integration and move to a D-SNP model. Demonstration states transitioning to a D-SNP model include California, Massachusetts, and New York.<sup>22</sup>

Though FIDE-SNPs and HIDE-SNPs are expected to grow, they currently occupy a small space in the D-SNP landscape and tend to be concentrated in a few states. One primary reason is that many states that use MCOs to



deliver Medicaid services have maintained important carve-outs of services for some or all of their dual eligible population. Also, although Medicaid managed care for dual eligibles is expanding, a significant minority of states continue primarily to rely on the fee-for-service model to deliver Medicaid services.

Currently, the vast majority of D-SNPs are not nearly as integrated as FIDE-SNPs or HIDE-SNPs. Their obligations to coordinate with Medicaid services are only very generally defined in federal regulations.<sup>23</sup> The one specific federal obligation for D-SNPs that are not FIDE-SNPs or HIDE-SNPs is that they must, for at least one subset of dual eligible enrollees, provide notice to the state when a member is admitted to a hospital or skilled nursing facility.<sup>24</sup>

Though states have the option of adding other specific requirements in their contracts, most states have not yet exercised that option to any significant degree.<sup>25</sup> CMS continues to encourage states to increase the integration of services in their D-SNPs.<sup>26</sup>

### Advocacy Opportunities

The dual eligible demonstrations have shown that improving data exchange and organizing care coordination among Medicare and Medicaid providers can be complex undertakings, at least at the start. The challenges can be particularly daunting when a state decides to move previously carved-out services, such as behavioral health, into managed care. Advocates can play an important role in helping to design integration protocols that maintain access to providers and ensure transitions happen smoothly. Safety nets and care continuity are of particular importance with any changes in delivery of behavioral health services.

## D-SNP BENEFIT PACKAGES CAN INCLUDE SUPPLEMENTAL BENEFITS

As with other Medicare Advantage plans, D-SNPs may offer supplemental benefits beyond those offered by Medicare Part A or Part B. These can include extra health-related benefits such as coverage for dental visits or adult day health services, as well as non-medical benefits such as pest control or transportation for non-medical needs.<sup>27</sup> Through the SMAC contracting process, states have leverage to help ensure that supplemental benefit packages are appropriate for and accessible to SNP enrollees.<sup>28</sup>

One issue of concern is supplemental benefits that duplicate or overlap with Medicaid benefits already available to dual eligible D-SNP enrollees. CMS permits D-SNPs to offer such benefits. For example, a D-SNP may offer Non-Emergency Medical Transportation services or some dental coverage that overlaps with benefits also provided under the state's Medicaid program.<sup>29</sup> In many cases, overlapping services are of limited value to the plan member and can be difficult for the member to navigate. States can, however, use the contracting process to require that D-SNPs offer supplemental benefits that complement, rather than duplicate state services.

Another important issue regarding supplemental benefits offered by D-SNPs is that information is limited concerning how many D-SNP enrollees actually receive the supplemental benefits offered and, importantly, whether those who are most disadvantaged and those with the most needs have full access to the benefits. Data collection concerning uptake of supplemental benefits, including, specifically, demographic data is a necessary first step to determining whether supplemental benefits are being distributed equitably. The limited information that is available raises concerns. For example, a county-level analysis of the availability of supplemental benefits found that the number of Medicare Advantage plans, including but not limited to D-SNPs, that offered any non-medical supplemental benefits was, on average, lowest in counties with the highest poverty rates.<sup>30</sup>

## Advocacy Opportunities

Advocates can work with their state and with D-SNPs serving their area to ensure that supplemental benefits are robust and responsive to the needs of dual eligibles, and that they complement, rather than duplicate, benefits available through the Medicaid program. Advocates can also encourage their states to fill current information gaps by requiring data collection about use of supplemental services with an emphasis on data that will allow an equity analysis. Without basic demographic data, it is impossible for D-SNPs to know how well they are addressing equity and for regulators and stakeholders to evaluate their performance.

## SOME D-SNPS MUST OFFER INTEGRATED APPEALS AT THE PLAN LEVEL

CMS requires that FIDE-SNPs and HIDE-SNPs with exclusively aligned enrollment have integrated appeal processes. In other words, if a service might be covered by Medicare or Medicaid, the plan must review the request, applying all applicable Medicare and Medicaid coverage criteria, and send a single notice addressing both elements.<sup>31</sup> If a plan member appeals a denial, the plan must also undertake an integrated review and issue an integrated reconsideration notice. Exclusively aligned FIDE-SNPs and HIDE-SNPs also must provide an integrated grievance process.<sup>32</sup>

CMS encourages plans that are not FIDE-SNPs or HIDE-SNPs to integrate their appeal processes as much as possible. At a minimum, D-SNPs are expected to assist members in filing Medicaid appeals. CMS also expects them to ensure that D-SNP providers cooperate in providing documentation needed to support a Medicaid appeal.

### Example

Mr. Smith requests coverage from his FIDE-SNP for a power wheelchair prescribed by his physician. In its organizational determination, the plan must review his request under both Medicare's use-in-the-home standard and Medicaid's more expansive coverage criteria. If the plan denies the claim and Mr. Smith appeals, the D-SNP must conduct an integrated redetermination and again review the request under both standards.

## Advocacy Opportunities

Advocates can work with D-SNPs to ensure that all D-SNPs, including D-SNPs with minimal integration, have robust measures in place to assist members in navigating Medicaid appeals. This assistance should be available in all states, including those with fee-for-service Medicaid.

## LOOKING AHEAD

D-SNPs are here to stay and their enrollment continues to grow. For advocates, understanding D-SNPs is important both for assisting clients and for policy advocacy.

First, knowing the extent of D-SNP penetration in the state, the state's D-SNP enrollment rules and the scope of D-SNP services is valuable both to assist clients with enrollment choices and to help them navigate issues that arise

with delivery of services. We encourage advocates to explore and understand the D-SNP landscape in their state and the policies the state has implemented with D-SNPs. The list of SNPs in the back of the Medicare & You Handbook for the local area (the list immediately follows the list of regular Medicare Advantage plans) or the [Plan Compare](#) feature at the Medicare.gov website are good starting points for county information on D-SNP availability.<sup>33</sup> The Kaiser Family Foundation website provides statewide numbers.<sup>34</sup> Local State Health Insurance Assistance Programs (SHIPs) also are a resource on D-SNP availability. Advocates can ask their state for a copy of the current SMACs and for information on what, if any, additional provisions are in the contracts beyond the minimum federal requirements.

Understanding D-SNPs is also necessary so advocates can engage with their Medicaid program on the future of D-SNPs in their state. Advocates need to be aware of the levers available to states and federal agencies to affect D-SNP design and to engage as stakeholders, particularly at the state level, to help ensure that requirements for plans and their actual operations work effectively to meet the complex needs of dual eligible individuals and promote equity in plan delivery of services.

### **D-SNP Look-Alikes**

In recent years, some Medicare Advantage plan sponsors started to offer plans that are not D-SNPs but appeal almost exclusively to dual eligibles because of their cost and benefit structure. The dual eligible membership in these plans, known as “D-SNP look-alikes,” sometimes topped 95% but these plans did not have the beneficiary protections and state oversight of D-SNPs.<sup>42</sup> Close to 200,000 dual eligibles have enrolled in look-alike plans in 13 states.<sup>43</sup> Concerned with this development, CMS stopped approving new look-alike plans and, starting in 2023, will deny renewal to existing plans. CMS will, however, allow plan sponsors to transition members of those plans into a D-SNP operated by the same plan sponsor.<sup>44</sup>

# APPENDIX

## A SNAPSHOT OF DUAL ELIGIBLES

As of 2019, approximately 12.3 million individuals were eligible for Medicare and full Medicaid benefits. An additional 3.6 million were partial dual eligibles, that is, individuals whose Medicaid eligibility is limited to Medicare Savings Programs.<sup>35</sup>

Populations that have experienced systemic discrimination are disproportionately dually eligible. For example, individuals who qualify for Medicare based on disability, female Medicare enrollees, and Medicare enrollees of color are more likely to be dual eligibles than those who qualify for Medicare based on age, who are male, and who are white (See Figures 1-3).<sup>36</sup>

FIGURE 1  
Coverage Type by  
Medicare Eligibility, 2012

Source: PUF 2012 tab in Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0, 2006-2012 (02/2019).

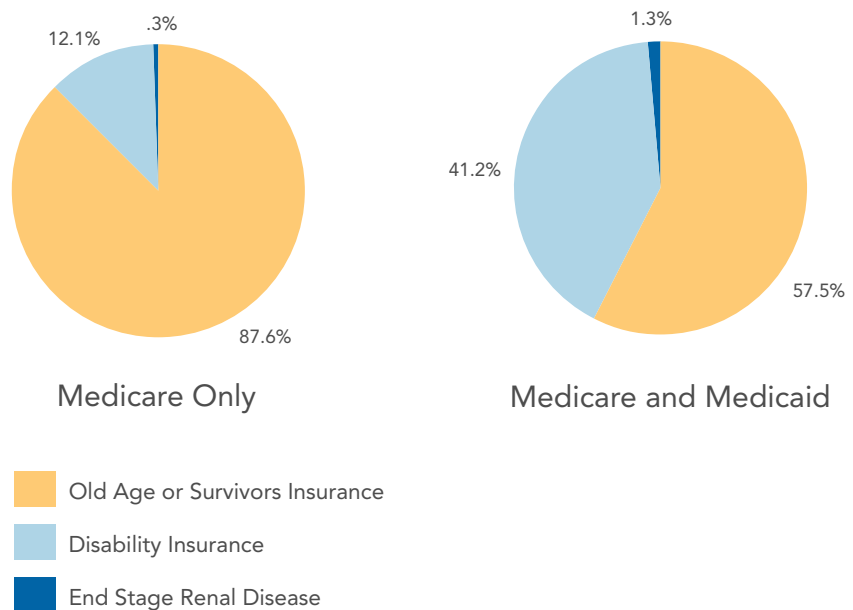


FIGURE 2  
Coverage Type  
by Race

Source: PUF 2012 tab in Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0, 2006-2012 (02/2019).

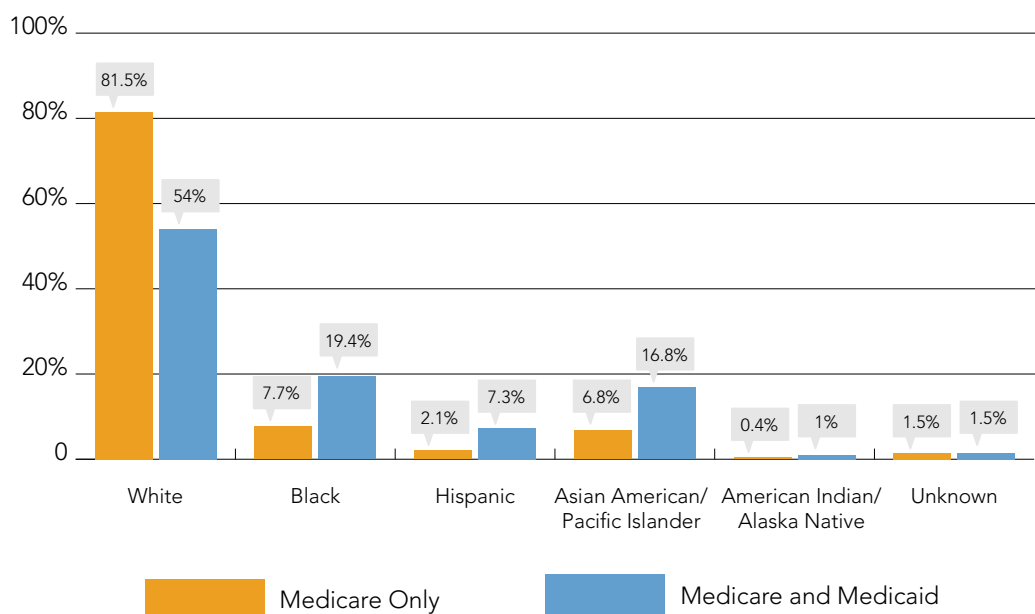
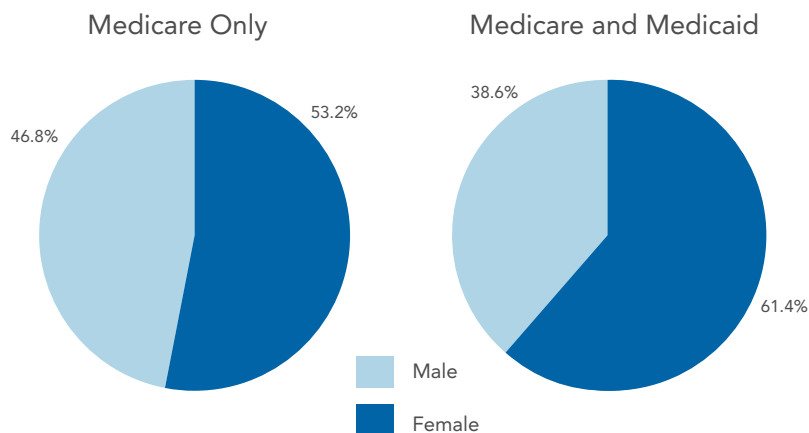




FIGURE 3  
Enrollment Type by Sex, 2012

Source: PUF 2012 tab in Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0, 2006-2012 (02/2019).

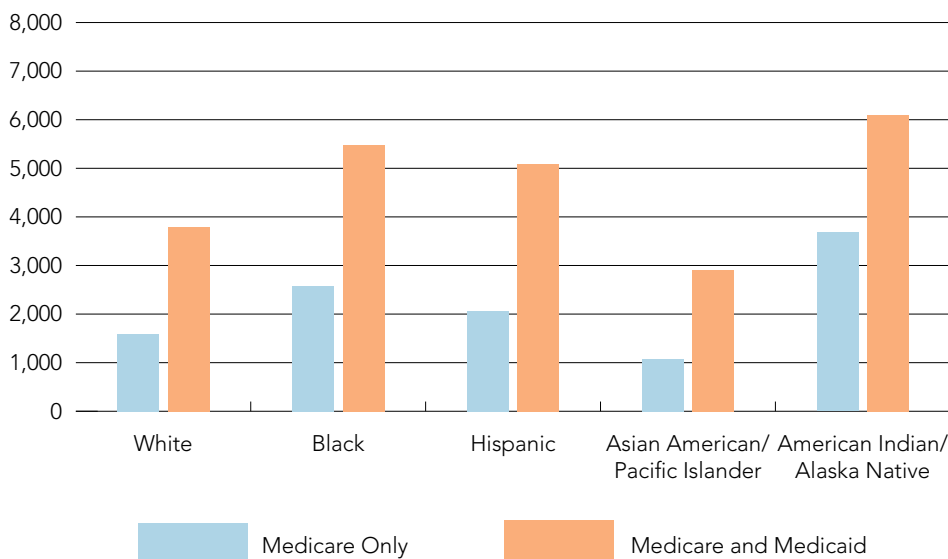


Dual eligibles are also in poorer health by most measures compared with the general Medicare population.<sup>37</sup> They are more likely to be readmitted to the hospital (19.8% versus 16.4%), nearly three times more likely to use the emergency department, and nearly three times more likely to be admitted to a skilled nursing facility than Medicare only enrollees.<sup>38</sup>

The pandemic exacerbated inequities in health outcomes for dual eligibles. Dual eligibles have been twice as likely to be diagnosed with COVID and 2.5 times more likely to be hospitalized for COVID than Medicare only enrollees (See Figure 4).<sup>39</sup>

FIGURE 4  
COVID-19  
Hospitalization  
Rates per 100,000  
by Coverage Type  
and Race

Source: CMS, *The Impact of COVID-19 on Medicare Beneficiaries in Nursing Homes*.



Dual eligibles are 8.5 times more likely to reside in nursing facilities, a factor that itself increases the likelihood of contracting COVID tenfold compared to individuals living in the community.<sup>40</sup> Black, Hispanic, American Indian, and Alaska Native Medicare enrollees required hospitalization for COVID at rates significantly higher than white Medicare enrollees regardless of dual eligible status.<sup>41</sup>

# ENDNOTES

- 1 Kaiser Family Foundation, [A Dozen Facts About Medicare Advantage in 2020](#) (Jan. 13, 2021).
- 2 42 U.S.C. § 1395w-28(f)(5)(A) (f) of the Social Security Act); For basic facts about enrollment and operations of SNPs, including D-SNPs, see CMS, [Special Needs Plans Frequently Asked Questions](#).
- 3 Bipartisan Budget Act of 2018 (P.L. 115-123).
- 4 Kaiser Family Foundation, [Fact Sheet Medicare Advantage](#), Fig. 4.
- 5 MACPAC, [Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans](#), p. 203 (June 2021) (“MACPAC, Improving Integration”).
- 6 Kaiser Family Foundation, [Medicare Advantage 2022 Spotlight: First Look](#) (Nov. 2, 2021) (“KFF First Look”).
- 7 MACPAC Draft Chapter: [Strategies for State Contracts with Dual Eligible Special Needs Plans](#) (Slide Presentation) (April 8, 2021), Slide 4.
- 8 MACPAC, Improving Integration, p. 204.
- 9 See, e.g., 42 C.F.R. § 422.107 and [Medicare Managed Care Manual, Ch. 16\(b\)](#).
- 10 42 U.S.C. § 1395w-28(f)(5)(A) (§ 1895(f)(5)(A) of the Social Security Act); see also CMS webpage “[Model of Care](#)” and NCQA webpage “[What is a Model of Care?](#)”.
- 11 42 U.S.C. § 1395w-28(f)(3) (Section 1859(f)(3) of the Social Security Act).
- 12 42 U.S.C. § 1395w-28(f)(3)(D) (Section 1859(f)(3)(D) of the Social Security Act); 42 C.F.R. § 422.107. For most plans, the minimum requirements are very limited, requiring D-SNPs generally to coordinate the delivery of Medicaid benefits, and specifically to notify the state Medicaid agency when a member of a subgroup designated in the contract is admitted to a hospital or skilled nursing facility. The Integrated Care Resource Center (ICRC) has developed model language for plans to implement the basic requirements. See ICRC, [Sample Language for State Medicaid Agency Contracts for Dual Eligible Special Needs Plans](#) (May, 2020). The ICRC document also includes sample optional contract language that states can use to further regulate D-SNPs.
- 13 MACPAC, Improving Integration, p. 437.
- 14 D-SNPs limiting membership to dual eligibles in institutional settings are rare but a small number exist including, for example, a few in Southern California. Note that these D-SNPs are distinct from Institutional SNPs (I-SNPs), which serve individuals in institutions but do not limit their enrollment to dual eligibles.
- 15 Contract language for limiting enrollment categories is found at ICRC, Sample Language, p. 17.
- 16 MACPAC, Improving Integration, p. 212.
- 17 ICRC Sample Language p. 17 (exclusive alignment) and p. 24 (alignment).
- 18 42 C.F.R. § 422.66(c)(2). For a fuller discussion of default options for states, see Ryan Stringer, [Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries](#) (ICRC, July 2019).
- 19 ICRC, [Default Enrollment Model Notice](#) (Oct. 2018).
- 20 See, e.g., [Financial Alignment Initiative, New York Fully Integrated Duals Advantage \(FIDA\) Program, First Evaluation Report](#), pp. 31-32 (Sept. 2019).
- 21 For details on the capitated models, see the [CMS webpage “Capitated Model”](#) and references cited therein. The ten states that participated in the capitated model are: California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia.
- 22 Virginia ended its demonstration in 2017. The remaining states are continuing their financial alignment demonstrations though they also permit D-SNPs.
- 23 In commentary, but not regulatory text, CMS stated that it generally expects plans to assist enrollees in finding appropriate Medicaid contacts, assist with filling out Medicaid forms, assist with obtaining documentation for filing a Medicaid appeal and the like. 84 Fed. Reg. 15680, 15696 et seq. (April 16, 2019). See also Justice in Aging, [CMS Regulations Set Ground Rules for D-SNPs](#) (2019).
- 24 42 C.F.R. § 422.107(d).
- 25 MACPAC, [Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans](#) (June 2021), pp. 203-204. See especially map on p.204.
- 26 See, e.g., CMS, [Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare](#) (State Medicaid Director

[Letter](#), Dec. 19, 2018).

- 27 For a discussion of the statutory and regulatory authority for different types of supplemental benefits, see ATI Advisory, [Advancing Non-Medical Supplemental Benefits in Medicare Advantage: Considerations and Opportunities for Policymakers](#), pp. 4-5, and ATI Advisory, [Providing Non-Medical Supplemental Benefits in Medicare Advantage: A Roadmap for Plans and Providers](#) (2020), pp. 5-7.
- 28 CMS, [Frequently Asked Questions on Coordinating Medicaid Benefits and Dual Eligible Special Needs Plans Supplemental Benefits](#) (May 27, 2021).
- 29 *Id.*
- 30 ATI Advisory, [Delivering on the Promise of the CHRONIC Care Act: Progress in Implementing Non-Medical Supplemental Benefits](#) (2021).
- 31 42 C.F.R. § 422.561. For specific requirements see 42 C.F.R. §§ 422.629, 422.631-422.634. These regulations implement the statutory mandate found at 42 U.S.C. 1395w-28(f)(8)(B).
- 32 42 C.F.R. § 422.630. For an in-depth discussion of the integrated appeals regulations and suggestions to states for implementing their requirements, see ICRC, [Integrated Appeal and Grievance Processes for Integrated D-SNPs with “Exclusively Aligned Enrollment”](#) (June 2020).
- 33 The county/region inserts in the Medicare & You Handbook are not available on-line but a paper copy can be requested from 1-800-Medicare. The Plan Compare feature is available at [Medicare.gov](#). See also KFF, SNP Enrollment *supra*.
- 34 Kaiser Family Foundation, [Medicare Advantage Special Needs Plan \(SNP\) Contracts, by SNP Type](#) | KFF.
- 35 CMS, [Data Analysis Brief: Medicare-Medicaid Dual Enrollment](#), 2006-2019.
- 36 CMS, [Medicare-Medicaid Linked Enrollee Analytic Data Source \(MMLEADS\) Public Use File \(PUF\)](#) Version 2.0, 2006-2012 (02/2019) | CMS.
- 37 *Id.*
- 38 *Id.*
- 39 CMS, [The Impact of COVID-19 on Medicare Beneficiaries in Nursing Homes](#).
- 40 *Id.*
- 41 *Id.*
- 42 85 Fed. Reg. 9002, 9019 (Feb. 18, 2020).
- 43 *Id.* at 9020.
- 44 42 C.F.R. § 422.514(d). For a fuller discussion of the final rule, see 85 Fed. Reg. 33,796, 33,805-820 (June 2, 2020).