Dual Eligible Special Needs Plans (D-SNP) Default Enrollment FAQs for SHIP Counselors in Wisconsin

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SHIP State Health Insurance Assistance Program

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Introduction

Wisconsin is enrolling Medicaid Supplemental Security Income (SSI) Health Maintenance Organization (HMO) members and Family Care Partnership Managed Care Organization (MCO) members directly in a Dual Eligible Special Needs Plan (D-SNP) managed by the same company when they become eligible for Medicare. Wisconsin is pursuing this change because research has shown that dual eligible beneficiaries' care is better coordinated when they receive both their Medicare and Medicaid benefits through one organization. This FAQ provides answers to common questions about this process for State Health Insurance Assistance Program (SHIP) counselors and other advocates.

Dual Eligible Special Needs Plans

1. What does dual eligibility mean?

a. Dually eligible individuals, also known as "duals," have both Medicare and Medicaid.

b. Medicaid members can get Medicare (and become "dually eligible") when they turn 65 years of age or reach their 25th month of receiving disability benefits.

c. "Dually eligible individuals" can be categorized in two sub-groups: full benefit duals and partial duals.

i. "Full benefit dually eligible individuals" have Medicare and full Medicaid benefits. They may or may not also have a Medicare Savings Program, which helps pay for Medicare premiums.

ii. "Partial benefit dually eligible individuals" have Medicare and partial Medicaid benefits. For example, they can get help paying for their Medicare premiums through the Medicare Savings Program but not have Medicaid health coverage.

Table 1: Categories of Dual Eligibility

	Full benefit dually eligible	**Partial benefit dually eligible**
Have Medicare	✓	✓
Have full Medicaid	✓	X
Have help with Medicare premiums through the Medicare Savings Program	**- (possibly)**	✓

2. What is a Dual Eligible Special Needs Plan (D-SNP)?

A Dual Eligible Special Needs Plan (D-SNP) is a Medicare Advantage plan that has a model of care and benefits designed specifically to serve the unique needs of dually eligible individuals. D-SNP contracts include requirements that the plan help coordinate Medicaid benefits for the member.

3. What is a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)?

a. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) are Medicare Advantage plans that have a model of care and benefits designed specifically to serve the unique needs of dually eligible individuals, like a regular D-SNP, but in addition must have a contract with the state Medicaid agency to provide coverage of primary, acute, behavioral health, and long-term services and supports benefits. FIDE-SNPs must also integrate or coordinate care management, member materials, member communications, and other processes such as grievances and appeals (see also Question 21).

b. Family Care Partnership D-SNPs are the only FIDE-SNPs in Wisconsin (see also Question 5).

c. In Wisconsin, all members in Family Care Partnership FIDE-SNPs are exclusively aligned, which means they must be enrolled in the same plan for both their Medicare and Medicaid benefits.

General Enrollment

4. Who can enroll in D-SNPs?

a. **Dually eligible individuals who have both Medicare and full Medicaid can enroll in D-SNPs.**

b. **D-SNP plans may choose whether they accept members with full Medicaid and/or partial Medicaid** (eg. different Medicare Savings Program tiers). Plans' Medicaid eligibility information is listed in a spreadsheet on the Department of Health Services (DHS) website's D-SNP webpage (https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling/d-snp.htm).

c. An individual must be a full benefit dual eligible (have full Medicaid benefits) and be enrolled in the **Family Care Partnership program** (see Question 5) to enroll in a Family Care Partnership FIDE-SNP.

d. **Note: Family Care** and Include, Respect, I Self-Direct (**IRIS**) participants may enroll in D-SNPs, but they are not aligned Medicaid MCOs available to them. In other words, the D-SNP company cannot manage or coordinate with their Medicaid benefits.

5. What are Family Care Partnership Medicaid MCOs?

Family Care Partnership is a Medicaid program that covers most Medicaid services as well as long-term care services. Those services are coordinated and paid for by the Family Care Partnership Medicaid MCO, or Partnership MCOs for short. Family Care Partnership members who are dually eligible are required to enroll in the MCO's D-SNP. Accordingly, the MCO will provide all Medicare, Medicaid (with a few exceptions), and long-term care services for dually eligible Family Care Partnership members.

6. What are SSI Medicaid HMOs?

a. Health maintenance organizations (HMOs) provide health care coverage to Medicaid members. SSI Medicaid HMOs (SSI HMOs for short) provide health care to members with SSI-related Medicaid, Medicaid Purchase Plan (MAPP), and other Medicaid programs. For more information, see the Wisconsin Medicaid SSI HMO Program Guide (P-12770).

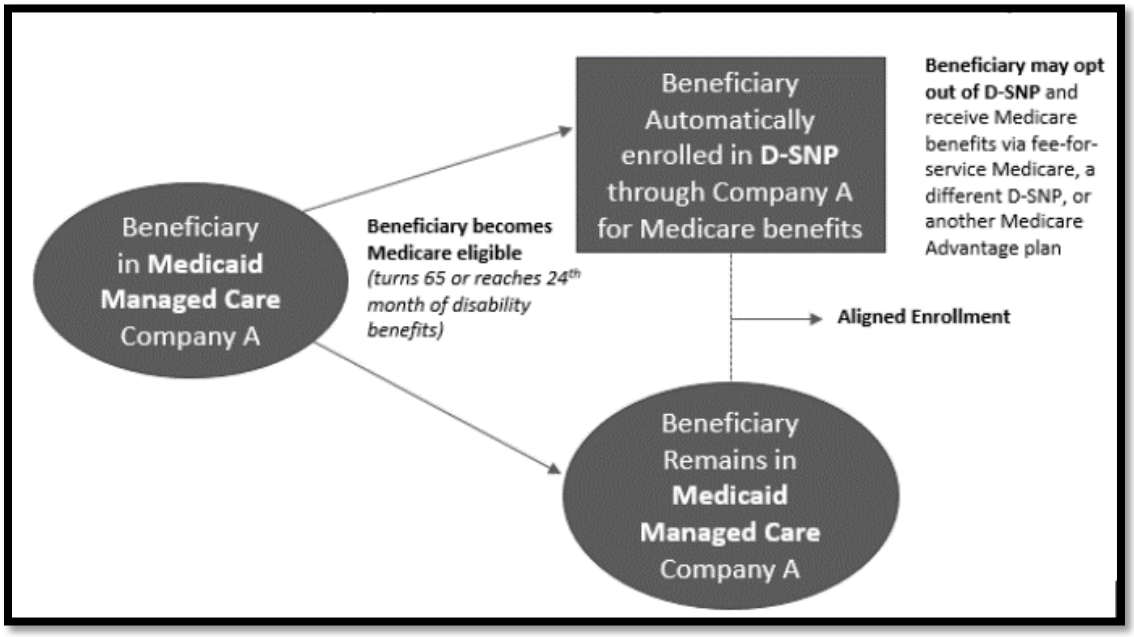
b. Dually eligible members who have both Medicare and Medicaid are not required to join SSI HMOs. They can choose to get fee-for-service Medicaid instead.

Default Enrollment Into D-SNPs

7. What is default enrollment?

a. Default enrollment is when individuals who are already enrolled in an SSI Medicaid HMO or Family Care Partnership Medicaid MCO are automatically enrolled in a D-SNP that is operated by the same company as the HMO or MCO when they become Medicare eligible for the first time (for example, when they turn 65 or reach their 25th month of disability benefits).

Figure 1: Default Enrollment



b. Individuals can opt out of the default enrollment (see Question 11).

8. Which D-SNP companies are eligible to conduct default enrollment in Wisconsin?

a. A D-SNP must have a Medicare.gov **Plan Finder star rating of at least three stars** to implement default enrollment.

b. D-SNPs can only automatically enroll members in counties where there is **substantial overlap in their Medicare and Medicaid provider networks**. The state defines substantial overlap as **80%** of the Medicare and Medicaid primary and specialty care provider networks.

c. There are 13 D-SNPs in Wisconsin. D-SNP companies are not required to implement default enrollment. The D-SNP companies electing to implement default enrollment may do so on a rolling basis, with default enrollment launching as they receive approval and get their systems in place.

d. Table 2 shows the D-SNP parent companies eligible to conduct default enrollment in Wisconsin.
   i. Ten of the 13 D-SNPs have aligned SSI HMOs. The parent companies are Elevance Health (formerly known as Anthem), Care Wisconsin/MyChoice Wisconsin, *i*Care, Managed Health Services Wisconsin, Molina, Network Health, Security Wisconsin, and UnitedHealth Care.
   ii. Three of the 13 D-SNPs are Partnership SNPs that have aligned Family Care Partnership MCOs. The parent companies are Care Wisconsin/MyChoice Wisconsin, Community Care, and *i*Care. These three Partnership D-SNPs are FIDE SNPs.

e. **A list of plans that implement default enrollment and their service areas can be found on the DHS D-SNP webpage.**

Table 2: D-SNP Parent Companies Eligible to Conduct Default Enrollment

Companies that are implementing default enrollment are **bolded**.

D-SNP Parent Companies with Aligned SSI HMOs	FIDE SNP Parent Companies with Aligned Family Care Partnership MCOs
Elevance Health (formerly Anthem) (effective Dec. 2023)	Care Wisconsin/MyChoice Wisconsin
Care Wisconsin/MyChoice Wisconsin	Community Care
***i*Care (effective late Dec. 2022)**	***i*Care (effective late Dec. 2022)**
Managed Health Services Wisconsin (effective Nov. 2022)	
Molina (effective Dec. 2022)	
Network Health	
Security Wisconsin	
UnitedHealth Care (effective Dec. 2022)	

9. Who will get default enrolled in a D-SNP?

a. Individuals enrolled in an SSI HMO or Family Care Partnership MCO who become newly eligible for Medicare as a full benefit dual-eligible are eligible for default enrollment. The individual must also live in a county in which the SSI HMO or Family Care Partnership MCO company also operates a D-SNP with at least 80% overlap between provider networks.

b. A list of plans that implement default enrollment and their service areas can be found on the DHS D-SNP webpage.

c. As shown in Table 3, members of the following Medicaid programs may be enrolled in an SSI HMO or Partnership MCO:
   i. Family Care Partnership
   ii. MAPP
   iii. SSI Medicaid
   iv. SSI-Related Medicaid
   v. SSI-Related Deductible
   Note: A member would only be eligible for default enrollment if their deductible is met when they become Medicare eligible.

Table 3: Members Eligible for Default Enrollment into a D-SNP

Medicaid Eligibility Groups	Default Enrollment
Family Care	X
Family Care Partnership	✔
SSI	✔
SSI-Related Medicaid	✔
SSI-Related Deductible	✔
MAPP	✔
BadgerCare+ (BC+) Parent/Caretaker	X
BC+ Childless Adult	X
BC+ Extension	X
BC+ Other	X

10. How does an individual learn they are being automatically enrolled in a D-SNP?

a. The D-SNP company will send the individual a "default enrollment notice" 60 days before Medicare becomes effective. The notice will include an opt-out form.

b. Sample of the notices sent to SSI HMO members and Family Care Partnership members can be found on the:
   - Department of Health Services (DHS) website's D-SNP webpage (https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling/d-snp.htm).
   - GWAAR Medicare Outreach and Assistance Resources webpage (https://gwaar.org/medicare-outreach-and-assistance-resources) under Dual Special Needs Plans (D-SNP).
   - SHIP Technical Assistance (TA) Center in the Resource Library.

c. If the individual actively enrolled in a Medicare Advantage or Part D plan, that choice will overrule the default enrollment (see Question 11).

11. When and how does an individual opt out of default enrollment?

a. To opt out, the individual must complete and **return the opt out form provided with their enrollment notice or call the D-SNP**. D-SNP's contact information can be found on the DHS D-SNP webpage and on the Medicare.gov Plan Finder tool.

b. An individual can opt out **any time prior to their Medicare effective date**, as outlined on the notice sent by the D-SNP 60 days before Medicare starts.

c. If an individual opts out but takes no action to select an alternative Medicare coverage option, **they will be automatically enrolled in a Part D plan**. It may be necessary to utilize LINET to fill prescriptions if there is a delay in the Part D plan start date.

d. If an individual actively enrolled in a different Medicare Advantage or Part D plan prior to or after receiving the D-SNP default enrollment notice, the **active enrollment choice will take priority** over the D-SNP. The member does not need to also submit the opt out notice if they have actively enrolled in a different plan. Members can call 1-800-MEDICARE to confirm their enrollment choice. SHIP counselors with Unique IDs can also call the Unique ID Helpline to confirm enrollment.

e. **If the default enrollment notice is returned to sender**, the D-SNP company must attempt to contact the member at least once using their preferred method (for example, phone, mail, or text) before the D-SNP plan becomes effective.

12. Can an individual switch to a different plan after being automatically enrolled in a D-SNP?

a. **Yes**. There is a **Special Enrollment Period that allows a onetime change within three months** of a state-initiated enrollment, starting with the notice of the change or the effective date of the change, whichever is later (CMS Managed Care Manual, Chapter 2: 30.4.7).
In other words, Wisconsinites who are automatically enrolled in a D-SNP have a Special Enrollment Period to change to a different plan within 90 days after Medicare starts.

b. Table 4 summarizes enrollment periods that may be available to dual eligibles:

Table 4: Enrollment Periods

Enrollment Period	Change	Time Frame
State-initiated enrollment (for example, default enrollment in a D-SNP) Special Enrollment Period (30.4.7)	Change health and drug plan to Original Medicare or a different Medicare Advantage plan	90 days after the new plan starts or the notice of change, whichever is later
Dual Eligible and Low-Income Subsidy Special Enrollment Period (30.4.4.5)	Add/drop/change PDP or MA-PD	One per quarter for the first 3 quarters of the year
Special Enrollment Period for Beneficiaries Age 65 (30.4.5)	If you enrolled in an Medicare Advantage plan during your 65th birthday Initial Enrollment Period: disenroll from the Medicare Advantage and elect Original Medicare	Any time during the 12-month period that begins on the effective date of coverage in the MA plan
5 Star Special Enrollment Period (30.4.4.15)	Enroll in a 5-star Prescription Drug Plan or Medicare Advantage plan with drug coverage	Once December 8–November 30, of the following year in which the plan received its 5-star rating
Annual Open Enrollment Period (30.1)	Add/drop/change Prescription Drug Plan or Medicare Advantage plan with drug coverage	October 15–December 7
Medicare Advantage Open Enrollment Period (30.5)	Switch Medicare Advantage plan or drop and enroll in a stand-alone Prescription Drug Plan	Once January 1–March 31

13. Why is Wisconsin pursuing this change?

Wisconsin is pursuing this change because research has shown that dual eligible beneficiaries' care is better coordinated when they receive both their Medicare and Medicaid benefits through one organization:

a. A study in Oregon showed improved care for beneficiaries with aligned enrollment.

b. Minnesota's Senior Health Options (MSHO) Program—similar in many ways to Wisconsin's Family Care Partnership Program—has shown improved outcomes for its dual eligible enrollees. A 2016 analysis found that MSHO enrollees, as compared to individuals with similar characteristics outside of MSHO, were:
   i. Less likely to have a hospital stay, and those who were hospitalized had fewer stays.
   ii. Less likely to have an outpatient emergency department visit, and those who did visit an emergency department had fewer visits.

iii. More likely to receive home and community-based long-term care services as opposed to long-stay nursing facility use.

A summary of this study is also available by the Integrated Care Resource Center (ICRC).

14. How many individuals will be affected by default enrollment?

The state estimates that up to 60 individuals a month will be eligible for default enrollment in a D-SNP (or less, if not all eligible D-SNPs choose to implement default enrollment).

Member Services

15. Where does an individual go to get information about their Medicaid coverage options?

Individuals can find out more about their Medicaid coverage by calling Member Services at 1-800-362-3002.

16. How will care and services be coordinated?

a. T**he D-SNP will help the beneficiary coordinate all their Medicaid and Medicare services, including hospital, medical, prescription drug, and long-term care needs**.
   i. Identify Medicaid participating providers for the members.
   ii. Identify Medicaid benefits the member may be eligible for under the Medicaid State Plan that are not covered services under the D-SNP, via the D-SNPs' Summary of Benefits.
   iii. Provide information, including contact information to access Medicaid benefits upon the member's request or as identified by the case coordinator or other health plan staff.
   iv. Coordinate access to Medicaid covered services upon the member's request or as identified by the plan's care coordinator, including identification and referrals to needed services, assistance in care planning, and assistance in obtaining appointments for needed services.
   v. Assist with questions about coverage or payment issues that may arise between Medicaid and Medicare upon the member's request or as identified by the plan's care coordinator.

b. **D-SNPs may assist with Medicaid redeterminations**. The level of assistance provided varies by plan; some just send reminders, while others have case managers who can assist with paperwork.

c. For Partnership D-SNP members, **the Partnership plan is responsible for coordinating all services required by the enrollee, as identified in their plan of care**. (Remember that Partnership D-SNPs are FIDE SNPs.) This includes:
   i. Any Medicaid benefits that are carved out of the capitated contract but provided under the Medicaid State Plan.
   ii. Waiver programs.
   iii. Medicare Parts C and D.
   iv. Other medically or socially necessary community services as identified in the enrollee's Plan of Care.

d. Partnership D-SNPs utilize all available data to coordinate all aspects of the member's integrated benefits, including:
   i. Discharge planning.
   ii. Disease management.
   iii. Care management.

e. To coordinate care, Partnership D-SNPs:
   i. Assign staff who are responsible for ensuring integrated Medicare-Medicaid benefits are coordinated. Coordination of Medicare and/or Medicaid benefits is not the enrollee's responsibility.
   ii. Have a process to share health risk assessment or other key data with the enrollee's primary care or specialty providers and with relevant Partnership case managers, contractors, or providers where information can inform shared care plan development.
   iii. Ensure care coordination works to support seamless care transitions, integrated care planning, and strategies to reduce unnecessary hospitalizations.
   iv. Have a unified appeals and grievances process (see Question 21).

17. Is there any impact on beneficiary services?

a. As the beneficiary is new to Medicare, Medicare becomes their primary payer for most services.

b. Beneficiaries should check that the D-SNP covers their prescriptions and that their preferred providers are in-network (see Questions 18 and 19).

18. How can an individual check if their primary care physician (PCP) and other providers are in-network?

The default enrollment notice will state whether an individual's primary care provider is in-network. The member should check whether other providers are in the D-SNP's network by calling the plan. Members can double-check that preferred providers are in-network by calling their providers as well. Links to the D-SNPs' provider searches can be found on the DHS D-SNP webpage.

19. How can an individual check if their prescription drugs are covered?

a. The default enrollment notice will include basic prescription drug cost information but not coverage information. Individuals should check if the D-SNP covers their drugs by either calling the plan, looking up the plan's formulary online, or looking up the plan on the Medicare.gov Plan Finder.

b. Medicare beneficiaries can get a 30-day transition refill for current prescriptions (for medically approved uses), even if the drug is not on their new plan's formulary.

20. How does an individual learn about their cost-sharing responsibilities under different D-SNPs?

a. **Ask the plan:** Individuals should review the copayments outlined in the default enrollment notice they received, call the plan, or look at plan details on the plan's website.

b. **Check the DHS D-SNP webpage:** Select plans' plan benefit packages are published. These webpages detail what costs are associated with what Medicaid programs. Links to plans' cost details are also in the D-SNP eligibility spreadsheet, which is posted to the DHS D-SNP webpage.

c. Alternatively, the **Medicare.gov Plan Finder** can provide this information. However, if the D-SNP offers different coverage for partial duals compared to full duals, Plan Finder will list both benefit packages without identifying which applies to the individual.

21. How do D-SNP members file appeals and grievances?

a. The appeals and grievance process will vary depending on the type of D-SNP members are enrolled in (for example, FIDE SNPs versus non-FIDE SNPs).

b. Family Care Partnership FIDE-SNP members file single, unified appeals and grievances whether the issue is related to Medicare or Medicaid, per 42 CFR 422.629–634. Only the three Partnership FIDE-SNPs (Care Wisconsin/MyChoice Wisconsin, Community Care, and *i*Care) have a unified appeals and grievance filing process.

c. For all other D-SNP members, the existing Medicare and Medicaid appeal and grievance processes apply. That is, individuals must follow separate Medicare and Medicaid appeal and grievance pathways.

d. Key comparisons between existing appeals and grievance processes and new integrated processes for Family Care Partnership FIDE-SNP members can be found in the Integrated Care Resource Center tool.

Reporting

22. How should SHIP counselors enter data for contacts about Special Needs Plans and default enrollment?

a. When entering data into the SHIP Tracking and Reporting System (STARS), select "Dual Eligible Special Needs Plans" as a Topic Discussed.

b. When assisting a beneficiary with default enrollment specifically, also type "default enrollment" into Special Use Field 3.

Glossary

Aligned enrollment: An individual's Medicare and Medicaid plans are provided by the same company

Automatic enrollment: When an individual automatically qualifies for the Low-Income Subsidy because they have Medicaid, they will get automatically enrolled in a Part D plan by Medicare unless they decline or actively choose their own plan

Default enrollment: The state enrolls SSI Medicaid HMO or Partnership MCO members in an aligned D-SNP when they become eligible for Medicare so that their Medicare and Medicaid services are provided by the same company

Dual/dually eligible: Individuals with both Medicare and Medicaid

- **Full dual**: Individual with Medicare and full Medicaid health coverage
- **Partial dual**: Individual with Medicare and partial Medicaid health coverage (for example, Medicare Savings Program only)

D-SNP: Dual Eligible Special Needs Plan, a type of Medicare Advantage plan available to only dually eligible individuals

EBD Medicaid: A group of Medicaid programs for the elderly, blind, and disabled

HMO: Health maintenance organization, a private company contracted to provide Medicaid benefits

ICEP: The Initial Coverage Election Period is the seven-month period during which a beneficiary who is newly eligible for a Medicare Advantage plan (for example, has both Medicare Parts A and B) can make a onetime enrollment in a Medicare Advantage plan; see 30.2 of the Medicare Managed Care Manual Chapter 2 for more information

IEP: The Medicare Initial Enrollment Period is the seven-month period during which an individual is first eligible to enroll in Medicare Parts A and/or B, which begins three months before and ends three months after the month that an individual turns 65 or reaches their 25th month of receiving disability benefits

LINET: The Limited Income Newly Eligible Transition program provides temporary prescription drug coverage to individuals eligible for the Low-Income Subsidy program whose Part D plan coverage hasn't yet started; learn more at www.humana.com/provider/pharmacy-resources/medicare-limited-income-net-program

LIS: The Low-Income Subsidy program, a.k.a. Extra Help, helps cover Medicare prescription drug costs; learn more at https://www.ssa.gov/benefits/medicare/prescriptionhelp.html

LTSS: Long-term services and supports, including home-based community services

MA: Medicaid Administration is an umbrella term for Medicaid programs

MA: Medicare Advantage (also known as Part C) plans are private companies contracted by the government to provide Medicare Parts A, B, and sometimes D benefits. Medicare Advantage plans have provider networks and set their own cost structuring. Learn more at medicare.gov.

MA-PD: Medicare Advantage plan with prescription drug coverage

MCO: Managed care organization, a private company contracted to provide Medicaid and long-term services and supports to Partnership participants

MSP: Medicare Savings Programs help pay for certain Medicare costs, such as the Part B premium

- There are different tiers of coverage:
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-Income Medicare Beneficiary (SLMB)
  - Specified Low-Income Medicare Beneficiary Plus (SLMB+)
  - Qualified Disabled and Working Individuals (QDWI)
- Learn more at www.dhs.wisconsin.gov/library/p-10062.htm

OEP: The Medicare Open Enrollment Period (also known as the Annual Election Period or AEP) runs from October 15 to December 7 every year. During this time, beneficiaries can change or drop their Part D or Medicare Advantage plan, with the change becoming effective the first day of the next calendar year.

Partnership: Family Care Partnership, an integrated health and long-term care state program for frail elderly and people with disabilities; learn more at https://www.dhs.wisconsin.gov/familycare/fcp-index.htm

PCP: Primary care physician

PDP: Medicare Prescription Drug Plan; private companies provide Medicare prescription drug coverage through Part D plans or Medicare Advantage plans that offer drug coverage (MA-PDs)

SEP: Medicare Special Enrollment Periods are opportunities to make changes to one's Medicare coverage and are triggered by qualifying events or circumstances.

SPAP: State Pharmaceutical Assistance Program; a state program that helps pay for prescription drugs. Certain tiers of Wisconsin's SeniorCare program qualify as a State Pharmaceutical Assistance Program.

SSI: Supplemental Security Income; a federal program operated by the Social Security Administration that provides monthly payments to eligible individuals who have limited income and assets. SSI recipients automatically qualify for Medicaid and may enroll in an SSI Medicaid HMO.