



A Brief Overview of Key Beneficiary Protections in Medicare-Medicaid Integrated Programs

August 2021



The information included in this brief summarizes federal requirements that establish a national standard for Medicare Advantage and integrated plan offerings. In most instances, for integrated programs states may impose rules and requirements above and beyond what is mandated at the federal level.



THE ISSUE

Beneficiaries covered by both Medicare and Medicaid (“dual eligible beneficiaries”) typically experience fragmented and misaligned care and must navigate two large, uncoordinated insurance programs. States and the Centers for Medicare & Medicaid Services (CMS) have aimed to address this fragmentation through the development of targeted and integrated programs that allow a more seamless experience for dual eligible beneficiaries and offer beneficiary protections.

While these protections exist at the program and policy level, little is known about how they translate into beneficiary experiences.

Study Overview and Findings

We undertook this study to identify beneficiary protections available to dual eligible beneficiaries through integrated programs.

Medicare-Medicaid Integrated Plans:

- 1 Include core provisions that ensure dual eligible beneficiaries have access to adequate, affordable, and coordinated care
- 2 Are subject to strict marketing and enrollment provisions to ensure dual eligible beneficiaries are enrolled in an appropriate product
- 3 Offer coordinated and in some instances aligned appeals and grievances processes
- 4 Must ensure sufficient education and culturally competent approaches

Background

Integrated Programs Offer Protections to Dual Eligible Beneficiaries

Dual eligible beneficiaries have considerably greater medical, functional, and social needs than the general Medicare population. These needs are exacerbated by the system fragmentation and misalignment that exists between Medicare and Medicaid. Integrated programs aim to simplify and improve the Medicare and Medicaid experiences for dual eligible beneficiaries. Additionally, health plans operating in these programs often are held to high standards of consumer protection.

What Integrated Programs are Available?*

Dual-Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan limited to dual eligible beneficiaries. Unlike other Medicare Advantage products, D-SNPs must have a state contract (the State Medicaid Agency Contract, or SMAC). States determine whether and which D-SNPs can be offered and, through the SMAC, can add program requirements to promote a high degree of integration with Medicaid. D-SNPs must cover Medicare Part A, B, and D services, and may cover supplemental benefits that go beyond Traditional Medicare.

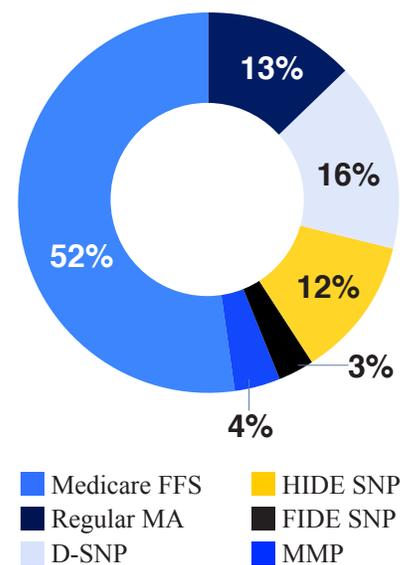
Highly-Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) are a type of D-SNP that provide Medicaid behavioral health and/or long-term services and supports (LTSS) consistent with state policy, through a capitated Medicaid managed care contract with a state.

Fully-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) are a type of D-SNP that provide access to Medicare and Medicaid benefits under a single legal entity, including Medicaid LTSS and/or behavioral health services consistent with state policy. FIDE SNPs must include at least 180 days of Medicaid nursing facility coverage.

Medicare-Medicaid Plans (MMPs) are a three-way partnership between a state, CMS, and a managed care plan with a single contract that includes comprehensive Medicaid and Medicare benefits, a single set of member materials, and aligned administrative processes.

*This study does not include managed fee-for-service MMP or PACE

June 2021 Dual Eligible Enrollment by Program



Approximately 12 million individuals are dual eligible beneficiaries. The majority (65%) are enrolled in non-integrated Traditional Fee-for-Service (FFS) Medicare or regular Medicare Advantage (MA).

Beneficiary Protections by Program

1 Core Protections

Dual eligible beneficiaries experience varying degrees of protection depending on the program and plan type they enroll in. At a minimum, Medicare Advantage (MA) plans must meet certain requirements with respect to the network adequacy of the coverage they provide, and the cost sharing restrictions that protect beneficiaries' out-of-pocket expenses.

	Traditional Fee-for-Service	Non-SNP Standard MA	D-SNP (including HIDE and FIDE SNP)	MMP
General (related to dual eligible beneficiaries)	N/A	N/A	All D-SNPs must have an approved Model of Care (MOC) that details how it will meet the unique needs of dual eligible beneficiaries, and on which its staff are trained	Program includes an MOC requirement, a Contract Management Team to oversee and ensure beneficiary protections, and an Ombudsman Program in each MMP state
Coordination and Integration with Medicaid	N/A	N/A	All D-SNPs must coordinate with Medicaid regardless of whether the D-SNP bears risk for Medicaid; at a minimum this includes assisting members with understanding their Medicaid benefits and sharing data with the state on Medicare admissions to facilitate Medicaid transitions of care	MMPs must provide and coordinate all necessary Medicare and Medicaid services
Provider Access and Engagement	N/A	Plans must maintain and monitor a network of providers that is sufficient to provide adequate access to covered services	In addition to MA network adequacy, D-SNP MOC requirements include a network targeted to dual eligible beneficiaries; D-SNPs enrollees also have an Interdisciplinary Care Team (ICT) with expertise and capabilities that align with their identified clinical and social needs	MMPs must provide beneficiaries with ICTs and must use the ICTs to coordinate care; MMPs have unique network adequacy standards specific to dual eligibles in their service area
Cost Sharing and Balance Billing	Nonparticipating providers may balance bill beneficiaries, with notice	All MA plans must adopt measures to protect dual eligible beneficiaries from improper billing and educate network providers about applicable billing requirements	In addition to meeting MA requirements, D-SNPs cannot impose any cost sharing that would exceed the amount permitted under the state Medicaid plan	MMP members have no cost sharing or deductible for any Part A or B services

Beneficiary Protections by Program

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Marketing and Enrollment

All Medicare Advantage plans are subject to strict marketing, communication, and enrollment guidelines to ensure beneficiaries have accurate information and the ability to enroll and disenroll freely and knowledgeably when eligible.

	Traditional Fee-for-Service	Non-SNP Standard MA	D-SNP (including HIDE and FIDE SNP)	MMP
Marketing and Other Communication	N/A	Non-D-SNP plans are not permitted to imply the plan is designed for dual eligible beneficiaries, claim they have a relationship with the state Medicaid agency, or target marketing exclusively to dual eligible beneficiaries; also, beneficiaries have separate member materials between Medicare and Medicaid	At minimum, D-SNPs must include specific information relevant to dual eligible beneficiaries such as Medicaid eligibility, cost sharing, a description of Medicaid benefits; some D-SNP materials are integrated with Medicaid materials such as a single member ID card and an integrated Summary of Benefits	Marketing and other communications are fully integrated and developed jointly by CMS and the state
Special Election Period	N/A	In addition to regular Medicare enrollment periods, dual eligible beneficiaries have access to a quarterly Medicare Advantage special election period during which they can disenroll from an MA plan into Traditional FFS or another MA plan including SNPs; the enrollment change is effective on the first day of the following month		State MMP programs may have a quarterly special election period <i>or</i> a continuous special election period
Loss of Eligibility and Deeming Period Coverage	N/A	N/A	Members must receive written notice regarding the loss of special needs status within 10 days; regardless of the date they lose status, the MA organization must provide a minimum of 30 days advance notice of disenrollment; a SNP may continue to provide care for an individual who loses status (“deeming period”) if the individual can reasonably be expected to meet the special needs criteria within six months	Members must receive written notice regarding the loss of Medicaid or State-specific eligibility within three business days of the determination; in this instance, an MMP may choose to provide a two-month period of deemed continued Medicaid eligibility for continuity purposes

Beneficiary Protections by Program

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Appeals and Grievances

Medicare and Medicaid have different appeals and grievance processes, including distinct rules and protections related to levels of appeal, review entities, timelines for filing appeals and grievances, and rendering a decision. This can create burden and confusion for dual eligible beneficiaries, particularly for services covered by both programs.

	Traditional Fee-for-Service	Non-SNP Standard MA	D-SNP (including HIDE and FIDE SNP)	MMP
Appeals and Grievances	A dual eligible beneficiary must navigate separate appeals and grievances process for Medicare and Medicaid, including distinct rules and protections related to levels of appeal, review entities, timelines for filing appeals and grievances, and rendering a decision		At a minimum, a D-SNP must offer assistance with navigating Medicaid appeals and grievances, regardless of whether the services are covered through Medicaid FFS or managed care; exclusively aligned* D-SNPs must have a single, unified appeals and grievance process whether the issue is related to Medicare or Medicaid, detailed below	Dual eligible beneficiary has a single, unified appeals and grievances process whether the issue is related to Medicare or Medicaid

*Exclusively aligned D-SNPs have membership such that every enrollee in the D-SNP receives their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent company.



Process. An applicable integrated plan must create integrated processes for enrollees for grievances, organization determinations, and reconsiderations. A State may implement standards for timeframes or notice requirements that are more protective for the enrollee.



Support. The applicable integrated plan must provide an enrollee reasonable assistance in completing forms and taking other procedural steps related to integrated grievances and integrated appeals.



Expertise. Individuals making decisions on integrated organization determinations must have knowledge of both Medicare and Medicaid coverage criteria.



Continuation of Benefits. The applicable integrated plan must continue the enrollee's Medicare Part A and B benefits while a reconsideration is pending if specific requirements are met.



Notices. Plans must issue an integrated denial notice (IDN) upon denial, in whole or in part, of an enrollee's request for coverage and in the event of discontinued/reduced treatment coverage. The IDN integrates information required of both MA and Medicaid.

Beneficiary Protections by Program

4 Consumer Education and Cultural Competency Requirements

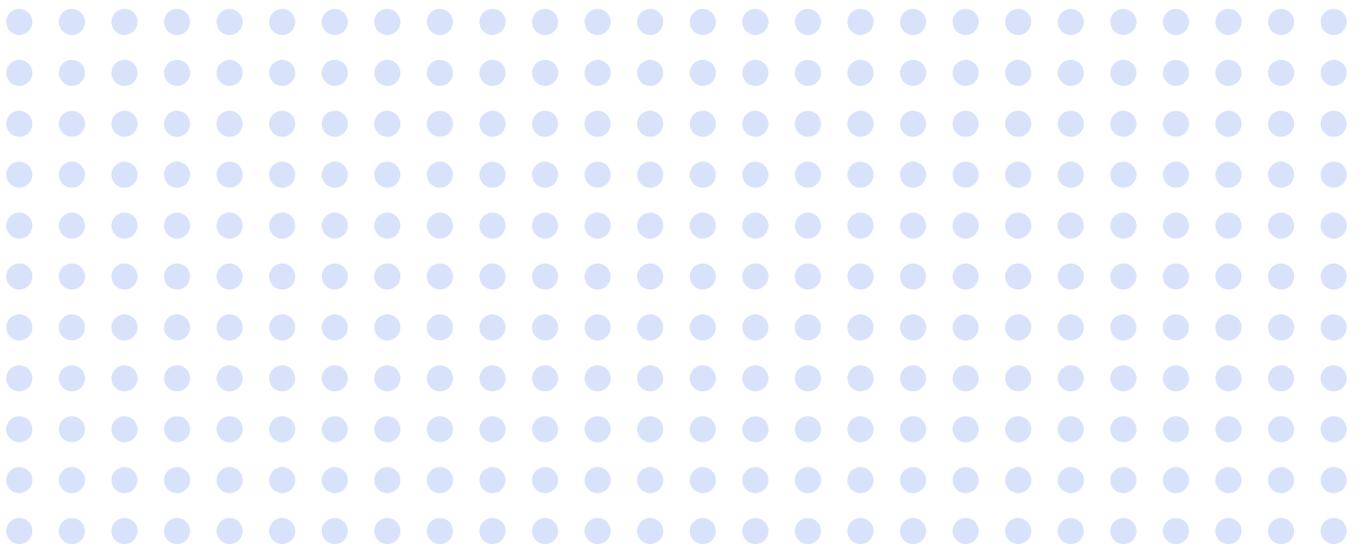
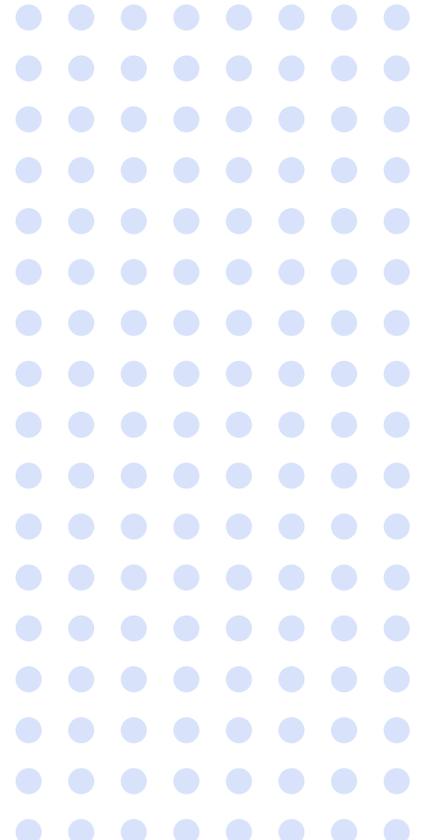
Integrated plans enroll some of the most vulnerable individuals with the greatest care needs.

To ensure those individuals the highest protection, plans must offer information in a form that is highly accessible and that respects the cultural diversity of each plan's enrollees. Beyond federal law, requirements obligating plans to educate enrollees and to provide culturally-competent coverage are found primarily in state law. Rules governing the ways that Medicare Advantage plans must communicate with their enrollees set a floor, which integrated plans exceed.

	Traditional Fee-for-Service	Non-SNP Standard MA	D-SNP (including HIDE and FIDE SNP)	MMP
Non-Discrimination	N/A	All MA plans are expected to ensure providers do not discriminate against enrollees based on receiving Medicaid; all plan benefits must be offered uniformly to all enrollees residing in the service area of the plan; an MA plan may not deny, limit, or condition enrollment on the basis of any factor that is related to the individual's health status		Subject to MA non-discrimination requirements
Required Communication	Medicare manuals for all beneficiaries (FFS or MA) are available in more than 20 languages	Call centers and plan materials must be accessible to limited English proficient beneficiaries, available in any language that is the primary language of at least five percent of a plan's service area		
Cultural Competency	N/A	MA plans must ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds	In addition to MA requirements, MOC includes demonstrating an understanding of the ethnic profile and needs of dual eligible beneficiaries	MMPs must provide care in a way that meets the enrollee's needs and that is sensitive to the enrollee's language and culture, is person-centered, and can accommodate and encourage consumer direction

Conclusion

Dual eligible beneficiaries include the most vulnerable individuals in the Medicare and Medicaid programs, and often must navigate two fragmented, misaligned programs. Because of this system complexity, CMS and states have developed integrated programs that include important beneficiary protections. While these protections exist, it is not clear whether they are sufficient or what the individual-level impact is on dual eligible beneficiaries. Moving forward, more research is needed to quantify the impact. This brief identifies key protections that should be explored in greater detail.



Resources

1 42 CFR § 422.112

2 42 CFR § 422.629

3 ATI Advisory. “Enrollment, Environment, and Efficiency: How the New Perennial Consortium Checks the Boxes For I-SNP Readiness.” [atiadvisory.com](https://atiadvisory.com/advancing-the-policy-environment-to-address-the-unique-needs-of-partial-dual-eligible-beneficiaries/Enrollment). <https://atiadvisory.com/advancing-the-policy-environment-to-address-the-unique-needs-of-partial-dual-eligible-beneficiaries/Enrollment>:

4 Barnette, Lindsay. 2017. “Medicare-Medicaid Plan (MMP) Application of Deductibles and Cost-Sharing when Reimbursing Non-Contract Providers.” CMS. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/mmp%20non-contract%20provider%20payment%2012.05.2017-508_16.pdf

5 CMS Medicare-Medicaid Coordination Office (MMCO). 2020. “Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019.” <https://www.cms.gov/files/document/medicaremedicaiddualenrollmentteverenrolledtrendsdatabrief.pdf>

6 CMS. 2013. “Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.” <https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/downloads/mmpfinalenrollguidance.pdf>

7 CMS. 2016. “Medicare Managed Care Manual Chapter 16-B: Special Needs Plans.” <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf>

8 CMS. 2016. “Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections.” <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>

9 CMS. 2018. “Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.” https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPEnrollmentGuidanceManual_CY2019_08022018.pdf

10 CMS. 2019. “Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans.” <https://www.cms.gov/files/document/dsnpartscdgrivancesdeterminationsappealsguidanceaddendum.pdf>

11 CMS. 2020. “Medicare Communications and Marketing Guidelines (MCMG)” https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/CY2019_Medicare_Communications_and_Marketing_Guidelines.pdf

12 CMS. 2020. “Medicare Managed Care Manual Chapter 2 - Medicare Advantage Enrollment and Disenrollment.” <https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf>

13 CMS. 2021. “Financial Alignment Initiative (FAI).” <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel>

14 CMS. 2021. “Medicare-Medicaid Plan (MMP) Marketing Information & Resources.” <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources>

15 Community Catalyst Inc. 2014. “Miles to Go: Progress on Addressing Racial and Ethnic Health Disparities in the Dual Eligible Demonstration Projects.” <https://www.communitycatalyst.org/resources/publications/document/Miles-to-Go-Health-Disparities-in-the-Dual-Eligible-DemonstrationsFINAL.pdf>

16 Donovan, Shannon. 2019. “Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs).” CMS. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf#:~:text=individuals%20in%20the%20FIDE%20SNP%20or%20HIDE%20SNP,Medicare%20and%20Medicaid%20benefits%20for%20all%20D-SNP%20enrollees>

17 Larrick Chavez-Valdez, Amy, Kathryn A. Coleman, and Lindsay P. Barnette. 2020. “2020 Readiness Checklist for Medicare Advantage Organizations, Prescription Drug Plans, Medicare-Medicaid Plans, and Cost Plans” https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2020%2520part%2520cd_mmp%2520readiness%2520checklist_12.pdf

18 Philip, Ann Mary, and Herman Soper, Michelle. 2016. “Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States” Center for Health Care Strategies. https://www.chcs.org/media/INSIDE ICTs_for_Medicare-Medicaid_Enrollees-012216.pdf

19 Section 1859(f)(7) of the Social Security Act

20 U.S. Department of Health and Human Services. 2017. “Section 1557: Frequently Asked Questions.” <https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html>