Designing Medicare-Medicaid Integrated Care Programs Centered on Enrollee Experience: A Toolkit for States

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The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

ABOUT THE SCAN FOUNDATION

The SCAN Foundation envisions a society where all of us can age well with purpose. We pursue this vision by igniting bold and equitable changes in how older adults age in both home and community. Our grants and impact investments prioritize communities that have been historically marginalized with an emphasis on older people of color, older adults with lower incomes, and older residents in rural communities. Learn more at **www.thescanfoundation.org**.

Contents

Introduction

For people dually eligible for Medicare and Medicaid, navigating two separate health insurance systems can make it harder to access coordinated, person-centered care. States play a critical role in designing integrated care programs that reduce fragmentation, improve enrollee experience, and better align coverage with people's goals and needs.

Many states are advancing integrated care for dually eligible individuals by incorporating requirements into their contracts with dual eligible special needs plans (D-SNPs) to align enrollment with Medicaid managed care organizations (MCOs). While this is an important step, states can do more to ensure that integrated care programs meet enrollees' goals and needs. Numerous studies have gathered feedback from dually eligible individuals about their care experiences, challenges navigating Medicare and Medicaid, and ideas for improving care.[1,2,3] However, most publications are not written for state Medicaid agency staff, who design and oversee integrated care programs and are well positioned to act on the findings.

With support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) reviewed existing research on the experiences of people dually eligible for Medicare and Medicaid and translated the findings into practical guidance for states. **This toolkit can help states with D-SNPs incorporate enrollee perspectives into policy, program design, and communications**. It can be used by state Medicaid leaders and staff responsible for D-SNP contracting and oversight to develop integrated care programs that better address the goals and needs of the dually eligible populations they serve.

To develop the toolkit, CHCS reviewed publications that gathered feedback directly from dually eligible individuals through interviews, focus groups, and surveys. CHCS organized the feedback into broad topic areas *(see Appendix)* and identified key findings.

CHCS then translated these findings into potential state actions that are feasible in the current policy and resource environment and responsive to enrollee priorities. To confirm that the findings reflected the priorities of dually eligible individuals, CHCS convened an advisory panel of people dually eligible for Medicare and Medicaid from across the country *(see Acknowledgments)*. To assess the actions' feasibility given current Medicaid priorities and state resources, CHCS convened an advisory panel of state Medicaid agency staff *(see Acknowledgments)*. The panel also considered how effectively each action could improve individuals' care experiences and interactions with the health care system.

This resulting toolkit includes four modules:

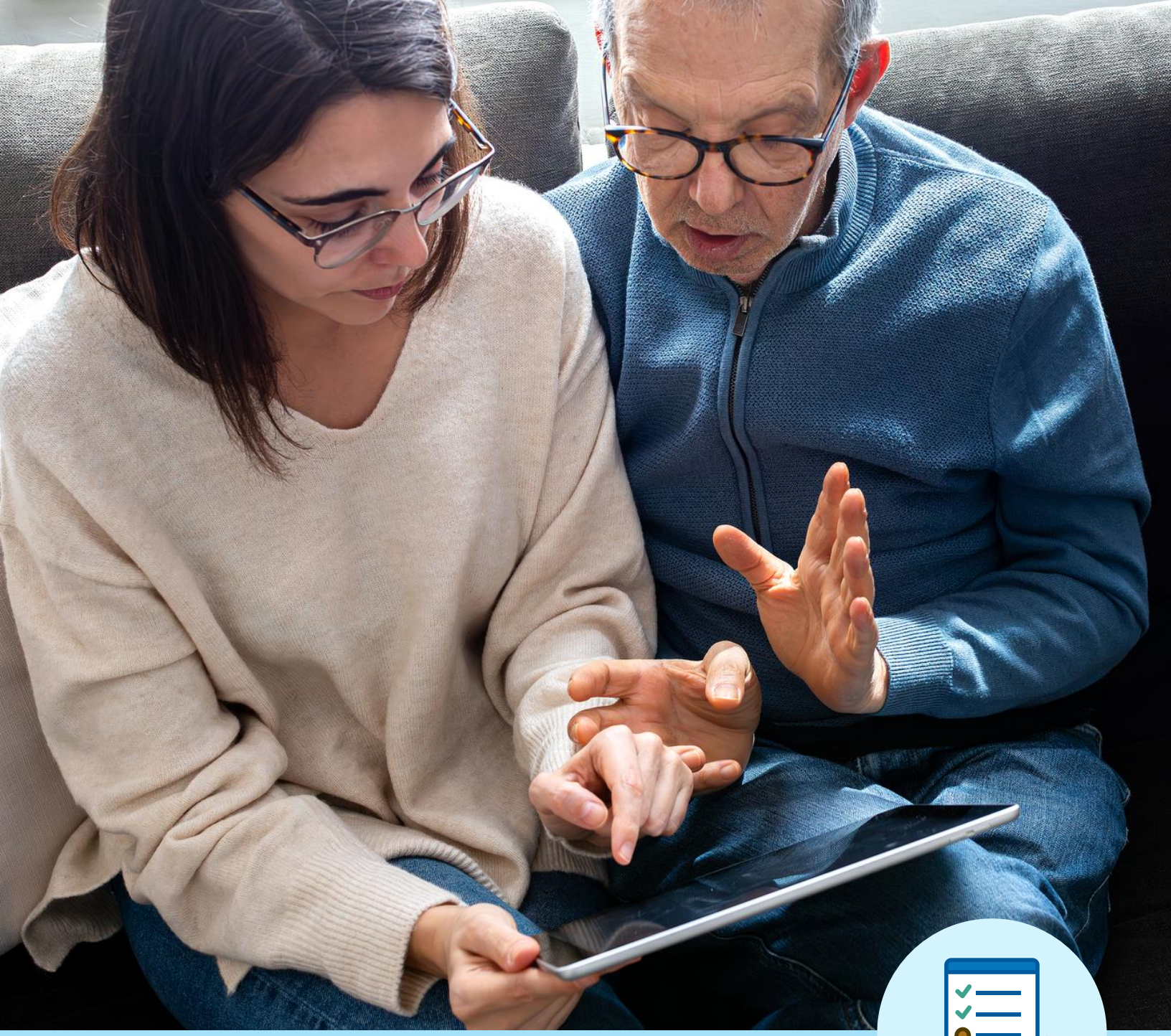
1. **Helping Dually Eligible Individuals Select Coverage**

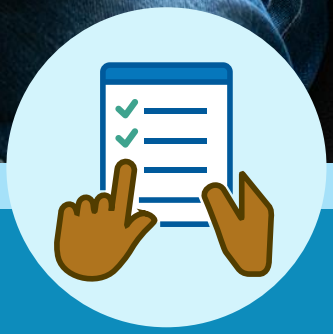
3. **Ensuring Access to Home- and Community-Based Services and Supporting Caregivers**

2. **Supporting Access to Care and Services**

4. **Improving Care Coordination and Reducing Fragmented Care**

Each module addresses one aspect of dual eligibility, such as health plan choice or provider access. Drawing on published research and advisory panel discussions, the modules describe dually eligible individuals' experiences and identify actions states can take. Each module also includes implementation resources.





MODULE 1

Helping Dually Eligible Individuals Select Coverage

People dually eligible for Medicare and Medicaid often have many options for receiving Medicare coverage. The volume and complexity of information about these options — including marketing from Medicare Advantage organizations — can make it difficult to select coverage that meets their needs. People who receive full Medicaid benefits may find value in coverage that integrates Medicare and Medicaid. However, health plan outreach and communications do not always clearly explain that integrated care programs are available or how these programs could meet a person's needs.

States can support enrollment in integrated care programs by clearly explaining coverage options and helping people identify the options that best meet their needs. States can also educate providers, enrollment assisters, agents and brokers, Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and community-based organizations so these partners can support informed enrollment decision-making.

This toolkit module summarizes feedback from dually eligible individuals regarding Medicare and Medicaid plan choice and outlines potential actions states can take to apply that feedback to policy decisions, program design, and enrollee communications.

What Do Dually Eligible Individuals Say?

Feedback from the literature and CHCS' advisory panel of dually eligible individuals shows widespread gaps in understanding Medicare and Medicaid coverage and what dual eligibility means. It also shows where people seek information and assistance and what factors shape their Medicare coverage decisions.

Widespread Confusion and Gaps in Understanding

Medicare's terminology, covered benefits, and enrollment processes are complex, **which can make the program difficult to navigate** for beneficiaries.[4,5] At the same time, Medicare resources that support coverage decisions — such as 1-800-MEDICARE, Medicare.gov, and the *Medicare & You* handbook — are not widely publicized and remain underused.[6]

Gathering Perspectives: *The People Say* Project

The People Say is an online platform featuring firsthand accounts from a diverse group of older adults and caregivers about their lives and the policy issues that affect them. The project, a joint initiative of Public Policy Lab and The SCAN Foundation, emphasizes perspectives often underrepresented in policymaking, including those of older adults of color, people with low incomes, and people living in rural communities.

CHCS reviewed relevant accounts from *The People Say* as one source informing this toolkit's discussion of dually eligible individuals' experiences. Throughout the toolkit, **links to selected video clips** allow readers to hear directly from older adults and caregivers about understanding coverage and navigating benefits.

These challenges can make it difficult for people with Medicare, including those who are dually eligible, to choose coverage that meets their needs. Current enrollment systems also may not clearly explain dual eligibility or the potential value of integrated coverage. Many dually eligible people are unfamiliar with integrated care models and how

they differ from traditional Medicare Advantage plans or fee-for-service Medicare.[7,8,9] One study found that people already enrolled in D-SNPs[10] were unfamiliar with terms such as "integrated care," "care coordination," and "dual eligible."[11]

In addition, language, cultural, and accessibility barriers can contribute to knowledge gaps. Research involving immigrants and people with limited English proficiency found that translated materials and interpretation services were not always available.[12] Human-centered design research also underscores that enrollment and communication systems do not consistently reflect people's lived experiences and accessibility needs, reinforcing systemic barriers.[13]

Marketing and Trusted Sources of Information

The volume and complexity of Medicare Advantage marketing can make plan information difficult to assess and contribute to confusion and distrust among potential enrollees, including dually eligible individuals. People often perceive the volume and complexity of Medicare Advantage marketing, including calls, mailings, and television ads, as excessive or misleading.[14] Research suggests that **communications do not always clearly distinguish plan promotions from official Medicare information**, which can increase skepticism and disengagement.[15] As one advisory panel participant said, "I have never gotten much help [choosing a plan]. I rely mostly on my friends for help. It is very confusing and I'm afraid of Medicare Advantage plans because I don't want to lose my doctors."

In response to these challenges, dually eligible individuals rely heavily on trusted sources of information, including family members, friends, and health care providers when making coverage decisions.[16,17] Family and friends often refer dually eligible individuals to brokers and insurance agents.[18] Community-based organizations are another trusted source.[19] Importantly, research also highlights that dually eligible beneficiaries with limited English proficiency often depend on family members or community advocates for enrollment support.[20,21] State Health Insurance Assistance Programs (SHIPs)[22] are used less often, possibly because this free, objective source of in-depth counseling does not always reach people who could benefit from it.[23,24,25,26]

Factors in Choosing Medicare Coverage

Three factors most often influence Medicare coverage decisions among dually eligible beneficiaries who enroll in a Medicare Advantage plan.[27] First, **studies identify low or no out-of-pocket costs as an important factor in coverage decisions**.[28,29] Second, people value supplemental benefits, including vision and dental coverage and debit-type cards for food, utilities, gas, and over-the-counter items.[30,31] Third, when choosing among Medicare Advantage plans, people consider whether they can maintain access to primary care, specialty care, behavioral health providers, prescription drugs, and long-term services and supports (LTSS)/home- and community-based services (HCBS) providers.[32,33,34] As a participant in CHCS' advisory panel of dually eligible individuals stated, "My priorities [when choosing a plan] are the cost of prescriptions, the participating pharmacies, and keeping my doctor."

The availability of plans that integrate Medicare and Medicaid benefits does not appear to strongly influence Medicare coverage decisions. One study noted that few dually eligible individuals were aware of the benefits of integrated care programs.[35]

State Actions in Response to Feedback

States can help people who are dually eligible understand coverage options and the potential benefits of integrated care. Several members of CHCS' state advisory panel reported conducting outreach and education, but they also cited limited budgets and staffing. As a result, states target available resources to the approaches they expect will have the greatest reach and impact. Panel members from states newer to Medicare-Medicaid integration wanted practical resources to strengthen communications with their dually eligible populations.

CHCS surveyed state advisory panel members to assess the feasibility and potential impact of the following four actions that states can take to improve communications with dually eligible individuals. The actions below are presented in ranked order:

1. Provide information about Medicare coverage choices on state Medicaid agency websites.

- **Description**: Creating or improving state websites can help dually eligible individuals and those who support them understand integrated care and identify coverage options that best meet their needs.
- **Considerations for Implementation**: States with established integrated Medicare-Medicaid programs often maintain websites or web pages that explain dual eligibility, describe integrated care programs, and outline potential enrollee benefits. Among states represented on CHCS' advisory panel, **California**, **Hawaii**, **Ohio**, and **Tennessee** have built their websites to provide information about D-SNPs. **Pennsylvania's** PA Link web page consolidates information about all aging- and disability-related services. Panel members from **Iowa** and **Kansas**, which are newer to integrated care program development, wanted to enhance their websites, but reported challenges identifying appropriate content and prioritizing resources.

  States can engage dually eligible populations in user testing to ensure web pages are clear and easy to navigate.

STATE SPOTLIGHT **Tennessee's D-SNP Website**

Tennessee has operated an integrated D-SNP program for more than a decade and has gradually built a robust and beneficiary-friendly website to explain the program and help dually eligible individuals choose the plan that best meets their needs.

The main D-SNP landing page features news and updates, explains D-SNPs and potential enrollee benefits, and provides eligibility and enrollment information, member stories, and additional resources. Among these resources is a downloadable, printable D-SNP brochure written in plain language.[36]

The Tennessee D-SNP Options page includes links to additional subpages for each D-SNP parent organization. Users can review Star Ratings and supplemental benefits, as well as plan documents such as the Summary of Benefits, Annual Notice of Change, Evidence of Coverage, and Drug Formulary. The D-SNP Resource page contains the same information in a comparison format.

- **Feasibility and Impact**: CHCS' state advisory panel ranked creating a state website to share information as the most feasible option for states to implement, given current priorities and resources. However, panel members thought state websites may have limited impact because they believe relatively few dually eligible individuals or their families or caregivers visit these websites.

2. Conduct direct outreach to dually eligible individuals through print, digital, and social media; town halls; and other activities.

- **Description**: Beyond official websites, states can use direct mail, digital and social media campaigns, webinars, and town halls to reach dually eligible individuals.
- **Considerations for Implementation:** In **Tennessee**, the state provides a member-facing brochure that D-SNPs can share with potential enrollees.[37] Other states, including **Ohio**, host tele-town halls or webinars to provide information to dually eligible individuals and their families. CHCS' state advisory panel recommended that speakers use plain language and limit insurance and health care jargon.

STATE SPOTLIGHT **Ohio's "Next Generation MyCare Community Visit" Outreach Activities**

As Ohio prepared for statewide implementation of its Next Generation MyCare integrated D-SNP program, it organized a series of events to publicize the launch and answer questions from dually eligible individuals, caregivers, advocates, and providers. During these Community Visit events, state staff shared information about the Next Generation MyCare program, explained how the change could affect participants and what actions they might need to take, and answered questions about the program.

Ohio held 11 in-person events across the state at locations including senior centers, AAA offices, and the Ohio State Fair. Staff from the Ohio Department of Medicaid, the state SHIP, and AAA participated. The visits drew 108 people.

Ohio also conducted eight implementation webinars. Each webinar was tailored to a different provider group (i.e., dental/vision, behavioral health, transportation, waiver providers, non-institutional providers, eligibility workers, advocacy groups and provider associations, and hospital providers). Together, the webinars reached 387 people.

To help support program launch, the state also created a web page with program resources, frequently asked questions, and a one-page program overview. The state also made the Ohio Medicaid Consumer Hotline available to answer questions. The program became available statewide in August 2026, and Ohio provides these and other support materials on its updated Next Generation MyCare webpage.

- **Feasibility and Impact**: CHCS' state advisory panel ranked direct outreach second in feasibility given current priorities and resources, but viewed its potential impact as relatively limited.

3. Train insurance agents and brokers, SHIPs, ADRCs, Ombuds programs, and other counselors.

- **Description**: States can train insurance agents and brokers; SHIP counselors and staff; ADRC staff; state long-term care Ombuds programs; or other entities that serve dually eligible individuals.
- **Considerations for Implementation**: In **Pennsylvania**, the state conducts trainings with its SHIPs, ADRCs, and Department of Aging staff who work with dually eligible individuals. The state also encourages MCOs and providers to share information through ADRCs. **Hawaii** trained SHIP counselors when it implemented default enrollment and now updates the training annually. The state also developed a frequently asked questions document for SHIP staff about exclusively aligned enrollment in D-SNPs and Medicaid MCOs. **Tennessee** plans to provide its SHIPs with additional training on D-SNPs and exclusively aligned enrollment before Medicare open enrollment for 2027 begins in October 2026. Hawaii and Tennessee commented that it is important to provide SHIP counselors with regular trainings to ensure that all staff are aware of current Medicaid policies and processes.

STATE SPOTLIGHT **Virginia's Training Requirements for Brokers and Agents**[38]

Virginia requires annual training for licensed insurance brokers and agents who support dually eligible individuals making Medicare enrollment decisions. The approximately 30-minute video is available on Virginia Medicaid's YouTube channel.[39] It covers Medicare Savings Programs, the benefits of Medicare-Medicaid integration, D-SNP eligibility, and exclusively aligned enrollment in D-SNPs and Medicaid MCOs. The video is updated annually as needed. Links are available in the *Resources for Health Plans* section of Virginia Medicaid's Medicare and Medicaid Programs web page.

D-SNPs must ensure their brokers have completed the training and provide proof of completion to the state upon request.

Virginia includes these training requirements in Section 6.2.1 of its state Medicaid agency contract (SMAC) with its D-SNPs using the following language:

> *A broker/agent is a trained insurance professional who helps individuals enroll in the D-SNP. Brokers/Agents may be employees of the Contractor or a subcontractor of the Contractor including those that represent several insurance companies.*
>
> *All brokers/agents must complete the Department's enrollment broker video training prior to working in Virginia. The broker/agent must complete updated trainings in order to ensure they are aware of important policy changes that may affect members. The Contractor must ensure each broker has completed the training and, upon request, must provide proof of completion to the Department.*
>
> *The Department will update the enrollment broker training for the upcoming plan year on an annual basis as needed and will make the video available to view online at the DMAS YouTube channel. The Department will provide the Contractor with the active link to the updated training video each year when it becomes available. The Contractor must ensure all Brokers/Agents complete the updated trainings prior to selling the Contractor's D-SNP products for the coming contract year. If no updates are needed to the video training for the coming plan year, the Department will notify the Contractor accordingly. If the training video has not been updated, brokers must view the existing video prior to selling the Contractor's D-SNP products for the coming contract year.*

- **Feasibility and Impact**: CHCS' state advisory panel ranked training agents, brokers, and counselors as moderately feasible given current state priorities and resources. Panel members considered training potentially highly effective, although it may require more effort and resources than putting information on a website or sending a mailing.

4. Educate providers, community-based organizations, and other trusted partners about integrated care options.

- **Description**: Dually eligible individuals often seek enrollment advice from providers, waiver case managers, and other organizations from which they receive services. States can educate these trusted partners about coverage options and the potential benefits of integrated care.
- **Considerations for Implementation**: **Pennsylvania** requires health plans participating in Community HealthChoices, its Medicaid managed LTSS (MLTSS) program, to ensure that network providers complete online training on the program and its approach to integrated care. The state's SMACs also require D-SNPs to train their network providers on Community HealthChoices and how it integrates the care of dually eligible enrollees.
- **Feasibility and Impact**: CHCS' state advisory panel ranked this action as slightly less feasible than training brokers, agents, or SHIP counselors, given current state priorities and resources. However, states felt this action was potentially the most effective of all the information dissemination strategies discussed in this module.

Tools and Resources for States

- **Dual Eligible Terms and Experience Study**. This report, developed for the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, includes terms and definitions, in English and Spanish, that people who are dually eligible prefer and understand. It also offers tips for plain language use and design best practices. *(Mathematica, September 2024)*
- **Integrated Care for People with Medicare and Medicaid**. This toolkit includes resources for dually eligible individuals and providers. In particular, see "Questions to Ask When Weighing Coverage Choices," the chart "Comparison: Original Medicare, Standard D-SNPs," and "Integrated D-SNPs." *(National Council on Aging)*
- **I/DD Dual Eligibility Toolkit**. This resource includes plain-language materials, in both English and Spanish, to help dually eligible individuals with intellectual and developmental disabilities (I/DD) and their families navigate enrollment and benefits. (*National Association of State Directors of Developmental Disabilities Services)*
- **Dual Medicare-Medicaid**. This Washington State website offers several educational resources, including the video "Transition from Apple Health Medicaid to Medicare" for people enrolled in Medicaid who are turning 65, and the "Medicare in 15 Minutes" training series. *(Washington State Department of Social and Health Services)*
- **Medicaid Agency Partnerships with State Health Insurance Programs (SHIPs): Opportunities to Improve Care for Medicare-Medicaid Enrollees**. This brief describes how state Medicaid agencies can partner with SHIPs to educate dually eligible individuals and those who support them about integrated care program options. *(Integrated Care Resource Center, July 2017)*

MODULE 2

Supporting Access to Care and Services

Navigating both Medicare and Medicaid can make it harder for people to access coordinated care. Differences between the programs' eligibility criteria, rules, and provider networks can contribute to fragmented care. People may struggle to find providers who accept their coverage, face long appointment waits, encounter service denials, or lose Medicaid coverage.

States can use their D-SNP contracting authority to ensure that these plans are helping dually eligible individuals access the care and services they need.

This toolkit module summarizes feedback from dually eligible individuals regarding access to Medicare and Medicaid services and outlines potential actions states can take to apply that feedback to policy decisions, program design, and enrollee communications.

What Do Dually Eligible Individuals Say?

Published research and CHCS' advisory panel of dually eligible individuals identify several barriers to care: too few providers who accept both Medicare and Medicaid or participate in plan networks; long waits and travel distances; unclear information about covered benefits and services; and loss of Medicaid eligibility. This section describes each barrier.

Limited Provider Networks

People who are dually eligible often have multiple chronic physical and behavioral health conditions and see a range of providers for the care and services they need. When choosing coverage, they prioritize keeping their providers because finding new providers and building new care relationships can be difficult.[40,41]

For people enrolling in D-SNPs, finding in-network providers who accept their coverage can be especially challenging. Before enrolling in a plan, dually eligible individuals often try to check whether their preferred providers are in the D-SNP's network. However, focus group participants in one recent study noted their providers often were not in-network or provider directories inaccurately listed providers as being in-network or as accepting Medicaid when they did not.[42,43] Other interviews and focus groups with dually eligible individuals found that directories also listed providers who were not accepting new patients.[44] These issues are a common source of frustration for dually eligible individuals.[45]

Access to some types of providers may be especially challenging. One published study found that dually eligible people reported few issues in accessing primary care physicians and even many types of specialists, but **those who needed mental health care had difficulty finding a provider**.[46] In contrast, other studies found more difficulty in accessing specialty care. For example, in one focus group of dually eligible individuals, participants said they had difficulty finding behavioral health providers, dentists, and gynecologists.[47] Members of CHCS' enrollee advisory panel had similar experiences. One panel member said, "I had a psychiatrist I really liked when I was on private insurance, then I had to switch to Medicaid. I asked the provider if she would take Medicaid and she said 'yes,' but she actually didn't. I lost coverage with that provider for two to three years until I got Social Security Disability Insurance, and then I was able to go back." Another advisory panel member said, "I have been referred to speech pathology, but I can't find anyone in [my state] who will take Medicaid."

Barriers to Provider Access

Even when providers accept both Medicare and Medicaid, people may encounter other types of provider access barriers, including limited appointment availability. In one study, dually eligible individuals described being told they would need to wait several months for appointments for pressing health needs, and expressed concern about the impact of these delays on their health.[48] Another study found that **dually eligible participants were able to find specialists accepting new patients, but many faced long wait times** for initial appointments.[49] However, once these individuals became established patients, they described having regular appointments and adequate access to care.[50] Other research reported waits of up to seven months for services.[51]

Prior authorization requirements are another access barrier. Focus group participants in one study raised concerns because they had complex and often urgent health needs.[52] In published evaluations of the demonstrations under the federal Financial Alignment Initiative, some dually eligible individuals also noted long waits for service authorizations.[53]

Some groups of dually eligible individuals may face added difficulty with provider access. For example, in one study, focus group participants in rural areas reported transportation barriers and too few local specialists.[54] Other research found that dually eligible individuals with I/DD did not enroll in Medicare Advantage plans — despite supplemental vision, dental, and hearing benefits — because they believed limited provider networks could not address their complex and co-occurring health conditions.[55]

Denials of Care and Lack of Clarity on Covered Benefits

Dually eligible individuals enrolled in health plans can experience barriers to care because requests for prior authorization have been denied or because of a misunderstanding or miscommunication about whether Medicare or Medicaid covers a service. A recent publication described focus groups in which some dually eligible individuals said they had successfully appealed denials of benefits, but all the focus group participants agreed that the appeals process is complex.[56]

Some dually eligible individuals have more difficulty navigating health plan appeals processes than others. In an evaluation of a **New York** demonstration, beneficiaries without support from a family caregiver reported less understanding of the appeals process than beneficiaries with family support.[57] The study also found that Spanish-speaking participants encountered additional barriers because individualized information — including reasons for denials — was not routinely translated into their preferred language.[58]

Role of Care Coordinators or Navigators

For dually eligible individuals enrolled in health plans, care coordinators or care navigators can help address access barriers by identifying available providers, arranging appointments, and supporting appeals.[59] However, not all enrollees receive this support.

In one study, some dually eligible individuals reported that a social worker or navigator from their plan was helpful, although few received this support.[60] The study found that few dually eligible individuals used plan navigators because navigators did not contact them or because plans required enrollees to request help.[61] The study's authors noted that individuals who received navigator support were more successful and reported less difficulty navigating coverage and benefits than individuals who did not receive support.[62]

Maintaining Medicaid Eligibility

While most dually eligible individuals experience stable Medicare coverage, a significant proportion lose Medicaid eligibility for short periods.[63,64] A recent focus group study involving groups of dually eligible individuals under age 65 found that complex Medicaid renewal procedures contributed to coverage gaps.[65] In another study, participants described gaining and retaining Medicaid eligibility as stressful.[66] A third study found that some dually eligible focus group participants were concerned about losing the Medicaid coverage that they believed was critical in meeting their needs.[67] Although most participants had not experienced a loss of Medicaid, some were concerned that changes in income, assets, or other eligibility requirements could affect future coverage.[68]

State Actions in Response to Feedback

States can help ensure that dually eligible individuals have access to needed care and services. Many members of CHCS' state advisory panel reported taking steps to promote access while continuing to explore approaches to remove access barriers.

The state advisory panel ranked the following three actions to improve access to care and services from most to least feasible:

1. Require D-SNPs to offer deeming periods for enrollees who lose Medicaid eligibility.

- **Description**: Requiring D-SNPs to offer deeming periods (up to six months of continued enrollment in a D-SNP after a loss of Medicaid eligibility) can help to preserve dually eligible individuals' access to key health care providers, D-SNP supplemental benefits, and care coordination while the person works to regain Medicaid coverage. Without a deeming period, the D-SNP must disenroll the person.

- **Considerations for Implementation**: The Centers for Medicare & Medicaid Services (CMS) allows D-SNPs to offer deeming periods of up to six months, in one-month increments, for enrollees who can be reasonably expected to regain Medicaid coverage within six months. D-SNPs must apply these policies consistently to all plan enrollees and inform enrollees about them.[69]

  During the deeming period, D-SNPs must continue to provide all Medicare-covered benefits but are not responsible for covering Medicaid benefits or Medicare premiums or cost sharing for which they receive capitated payments from a state.[70] As a result, the enrollee may be responsible for paying Medicare cost sharing and for any Medicaid services received from D-SNP network providers.[71] To avoid imposing these out-of-pocket costs on enrollees, D-SNPs may choose to pay for them at their own expense. While states cannot require D-SNPs to continue to pay for Medicaid-covered services during a deeming period, they can encourage them to do so by providing retroactive payment for Medicaid costs to the D-SNP (or its affiliated Medicaid MCO) for enrollees whose coverage is reinstated before the end of the deeming period.[72,73]

  Among states represented on CHCS' advisory panel, **California**, **Hawaii**, and **Ohio** require D-SNP deeming periods. California requires at least three months, while Hawaii and Ohio require six months. Panel members reported that their D-SNPs were largely receptive because deeming periods can help retain enrollees, although some plans raised concerns about state requirements.

States considering deeming periods may want to discuss potential concerns with D-SNPs early in the contracting process.

STATE SPOTLIGHT **California's Use of Deeming Periods**

California recognized that some dually eligible individuals lose Medicaid eligibility because of difficulties completing renewal requirements. The state therefore included a SMAC provision requiring D-SNPs to provide a deeming period of at least three months after notification that an enrollee has lost Medicaid eligibility. D-SNPs may offer up to six months of deemed eligibility.

State staff worked with their D-SNPs to analyze enrollment and disenrollment data and found that between 20 percent and 90 percent of enrollees, depending on the plan, regained Medicaid eligibility during the deeming period. State staff reported that several D-SNPs chose to provide a full six months of deemed eligibility.

After recently launching nine new D-SNPs, the state identified confusion about whether affiliated Medicaid plans must continue covering Medicaid services during the deeming period. State staff clarified that continued coverage is optional.

State staff reported that their deeming policies helped enrollees maintain access to care and D-SNPs retain enrollment.

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked deeming period requirements as a highly feasible way to have a relatively high impact on access to care.

2. Add SMAC requirements for percent alignment of Medicare and Medicaid provider networks.

- **Description**: Aligning D-SNP provider networks with affiliated Medicaid MCO networks can support access, care transitions, continuity of care, care coordination, and affordability. Network alignment can be especially valuable for individuals transitioning from Medicaid-only enrollment to dual eligibility because it can preserve established provider relationships.

- **Considerations for Implementation**: States can include requirements in their SMACs to promote alignment. Among states represented on CHCS' advisory panel, **Ohio** requires all Medicaid plan providers to be available to D-SNP enrollees. **Hawaii** requires at least 90 percent of providers in an affiliated Medicaid plan to participate in the D-SNP's network. Several other states, including **Indiana** and **Washington State**, require 80 percent provider network overlap. During an Integrated Care Resource Center webinar, Washington State staff described their provider access goals and approach to setting network alignment targets.[74]

  When setting network overlap targets, states can seek input from their dually eligible populations and partner with their D-SNPs to identify which types of Medicaid providers are most important to include. States will also need to consider how they will monitor D-SNPs' compliance with network alignment requirements.

STATE SPOTLIGHT **Ohio's Network Alignment Requirements**

In Ohio, the state requires plans participating in the MyCare Ohio Program — which aligns D-SNPs with Medicaid MLTSS — to employ a network development director.[75] This director oversees network development, network sufficiency, and network reporting. The role is intended to ensure that plans have adequate provider networks and appointment access, engage in network planning in response to identified unmet needs, and oversee their network provider workforce development.

Ohio's MyCare Ohio Program contracts also include additional access requirements.[76] All Medicaid plan providers must be available to D-SNP enrollees. The state also sets appointment availability standards. For example, enrollees requesting routine mental health or substance use disorder treatment must receive an appointment within 10 business days or 14 calendar days, whichever is earlier. For nonemergent/nonurgent dental services, including routine and preventive care, enrollees must receive an appointment within six weeks. In addition, MyCare Ohio Program plans must ensure that services are available 24 hours a day, seven days a week, when medically necessary. The state's external quality review organization conducts annual secret shopper monitoring to enforce appointment availability requirements.

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked network alignment requirements as highly feasible and likely to have a relatively high potential impact on improving access to care.

3. Use D-SNP care coordinators to help enrollees in finding available providers and scheduling appointments.

- **Description**: Network alignment alone may not ensure access to needed care and services. D-SNP care coordinators can help enrollees identify available providers and schedule appointments.
- **Considerations for Implementation**: CMS requires D-SNPs to cover all Medicare Part A and B benefits and assist enrollees in obtaining Medicaid-covered services.[77,78] However, these requirements are broad. Assistance with obtaining Medicaid benefits may be limited to explaining to the enrollee how to request a Medicaid service authorization or providing a list of network providers.[79,80] States can use SMAC requirements to specify how D-SNP care coordinators must help enrollees obtain needed care and services.

  To understand how D-SNPs help connect current enrollees to needed care, states can request that D-SNPs provide copies of their approved Model of Care (MOC). The MOC must describe how the D-SNP will conduct care coordination activities and ensure completion of appropriate follow-up, referrals, and scheduling for needed care or services.[81] States can use this information to work with D-SNPs on clearer, more effective enrollee support processes.

STATE SPOTLIGHT **Tennessee's Requirements for D-SNP Enrollee Access to Care**

Tennessee requires its D-SNPs to coordinate with their enrollees' Medicaid MCOs regarding needed Medicaid LTSS. This requirement supplements the D-SNP's responsibility to ensure access to all covered Medicaid benefits, including skilled nursing facility (SNF) and home health care. D-SNPs must also coordinate with Medicaid MCO coordinators or support coordinators to ensure timely access to medically necessary Medicaid benefits.[82]

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked adding specific SMAC requirements for how D-SNP care coordinators should help enrollees obtain needed care and services as moderately feasible and likely to help ensure access to care for dually eligible individuals.

Tools and Resources for States

- **Promoting Provider Network Alignment to Improve Integration in D-SNPs**. This webinar describes federal D-SNP provider network adequacy requirements. Washington State staff discuss the state's experience implementing, monitoring, and updating provider network alignment requirements. *(Integrated Care Resource Center, April 2026)*
- **Preventing and Addressing Unnecessary Medicaid Churn Among Dually Eligible Individuals: Opportunities for States**. This brief summarizes steps that states can take, including establishing deeming periods, to prevent unnecessary Medicaid eligibility loss and reduce the effects of temporary coverage gaps among D-SNP enrollees. *(Integrated Care Resource Center, March 2022)*
- **Leveraging Dual Eligible Special Needs Plan (D-SNP) Models of Care to Enhance Enrollee Care Coordination**. This webinar discusses strategies states can use to improve D-SNP care coordination. It reviews federal care coordination and MOC requirements, state options for adding care coordination requirements to SMACs or MOCs, and implementation considerations. *(Integrated Care Resource Center, April 2023)*
- **Expanding Access to Integrated Medicare-Medicaid Programs in Rural Communities**. This brief identifies partnership approaches, delivery flexibilities, and provider incentives for implementing integrated models in rural communities. Findings draw from a literature review, interviews with state officials, health plans, providers, and community-based organizations, and a convening of Medicaid leaders from eight states. *(CHCS, August 2025)*

MODULE 3

Ensuring Access to Home- and Community-Based Services and Supporting Caregivers

People who are dually eligible for Medicare and Medicaid often have multiple physical and behavioral health conditions and functional needs that can affect their ability to live independently. Nearly half report difficulty with one or more activities of daily living; 36 percent report a cognitive impairment; and 15 percent report a developmental disability.[83,84] For dually eligible individuals who receive full Medicaid benefits — often referred to as full-benefit enrollees — Medicaid covers LTSS, including institutional care and HCBS, to meet functional needs. Among full-benefit dually eligible individuals, 16 percent live in an institutional setting and 36 percent receive HCBS.[85]

Medicaid HCBS may be provided through a Medicaid state plan or Medicaid waiver programs. Services may include skilled nursing care, home health aides, personal care services, adult day health, habilitation, care management, supported employment, in-home therapies, equipment and technology, and caregiver supports.[86,87] Many dually eligible individuals also rely on family members and friends for assistance. Together, HCBS and support from family caregivers can help dually eligible individuals who require LTSS to remain in their homes, pursue education and employment, and stay connected to family, friends, and their communities.

This toolkit module summarizes feedback from dually eligible individuals about access to Medicaid HCBS and support for family caregivers. It also outlines potential actions states can take to incorporate that feedback into policy and program design.

What Do Dually Eligible Individuals Say?

Published literature and CHCS' advisory panel of dually eligible individuals identify several barriers to HCBS access, including authorization restrictions on personal care hours, low payment rates, direct care workforce shortages, and poor communication among payers and providers. In addition, challenges faced by family caregivers are also experienced by dually eligible individuals as limiting their access to HCBS. This section examines these challenges.

Access to and Quality of HCBS

Access to adequate HCBS is a central concern for many dually eligible individuals. Beyond state variations in what HCBS are offered[88] and waiting lists in many states,[89] enrollees cite authorization restrictions on personal care service hours as a key challenge. One member of CHCS' advisory panel noted, "An assessor cut my [personal care] hours because I didn't need as much help bathing once my pulmonary function test went up…However, my mobility, my chronic pain, my conditions are still arthritis and sciatica and all of the degenerative stuff means I'm moving less so I need more help." Similarly, focus group participants under age 65 in a Commonwealth Fund study said they valued independence, community integration, and respectful treatment from health care providers, but they were frustrated by unmet care needs when personal care services were limited.[90] Participants in a Community Catalyst project also rated access to services as the most important aspect of HCBS quality.[91]

Direct Care Workforce Shortages and Instability

Many in-home HCBS are provided by paid caregivers, also called direct care workers. Low payment rates and other challenges have contributed to a nationwide workforce shortage.[92] Dually eligible individuals describe stable, trusting relationships with direct care workers as critical to quality care, yet they often experience high turnover among personal care aides, disrupting long-term relationships. These disruptions can leave daily needs unmet, create stress, and require people to repeatedly coordinate their own care or find other ways to fill gaps.[93,94]

The Community Catalyst project also identified stable relationships with personal care aides as a key priority because an aide's work often involves intimate tasks (e.g., dressing, bathing, and toileting) and training a new aide to understand an individual's needs and preferences **takes time and effort**.[95] A member of CHCS' enrollee advisory panel said, "It would be nice if caregivers coming into the home had to fill out a questionnaire with questions about the person [they will be caring for]. [For example,] Do you want me to be right there with you? Do you need me to walk around with you, or do you need me to give you some time alone? Things like that, just to establish, it's sort of a friendship in a weird way, although … it's also professional, it's a job."

Family Caregivers Provide Essential Support, but Often Face Strain

Family caregivers play a central but often less recognized part in care delivery and system navigation. This role can lead to **financial strain, burnout, and feelings of obligation or burden for both caregivers and care recipients**.[96] A member of CHCS' advisory panel of dually eligible individuals said, "[Over] the last few years, I've needed more care and hours. My living attendant/partner is getting older, and with life and health issues, and the need for respite is very important but has not been easy to get."

For many younger dually eligible individuals, aging parents are a crucial source of assistance, leaving them concerned about a future without their caregiving support. Participants in the Commonwealth Fund study feared that without family caregivers or sufficient Medicaid-funded HCBS, they eventually might need to move to a long-term care facility.[97]

State Actions in Response to Feedback

States can help dually eligible individuals access HCBS. Depending on a state's coverage landscape, a state may have D-SNPs, Medicaid MCOs, and Medicaid HCBS waiver case management organizations. States can use contracts with these entities to ensure access to and coordination of HCBS for dually eligible individuals. States also have opportunities to support family caregivers of D-SNP enrollees. Members of CHCS' state advisory panel shared examples and implementation considerations. Given the anticipated impact of H.R. 1 (P.L. 119-21) on Medicaid budgets, the state actions offered in this section may be particularly valuable strategies for ensuring access to HCBS.

CHCS' state advisory panel rated two potential actions based on their feasibility and potential impact:

1. Strengthen communication among D-SNPs, Medicaid MCOs, and waiver case management organizations to ensure access to HCBS after care transitions and as enrollee needs change.

- **Description**: Supporting information exchange among D-SNPs, Medicaid MCOs, waiver case management organizations, and HCBS providers can help maintain access to services after care transitions. It can also help ensure that care plans reflect changes in an enrollee's health and service needs.

- **Considerations for Implementation**: D-SNP enrollees who use HCBS can encounter service disruptions when returning home from hospitals or SNFs. Medicare-covered hospital and SNF stays are covered by the individual's D-SNP and not by Medicaid, so the Medicaid MCO or waiver case management organization may be unaware that an enrollee has been admitted. If the enrollee is not at home or does not respond to calls or emails, the Medicaid entity may discontinue HCBS. Reestablishing services may take time, leaving care needs unmet or requiring family or friends to fill care gaps.

  States may want to consider their D-SNP landscape when developing strategies to enhance communication around dually eligible individuals' care transitions. CMS already requires coordination-only (CO) D-SNPs to notify the state or the state's designee when members of a state-designated group of high-risk, full-benefit dually eligible enrollees are admitted to a hospital or SNF for Medicare-covered care.[98] SMACs with CO D-SNPs must specify the high-risk group, the entity to which information must be sent, and the method and timeframe for data submission.[99] However, states can oversee these communications to ensure information is sent on time and used to coordinate care transitions.

  CMS does not apply the same information-sharing requirements to highly integrated D-SNPs (HIDE SNPs) or fully integrated D-SNPs (FIDE SNPs). However, states can strengthen communication between D-SNPs and Medicaid MCOs or waiver case management organizations to prevent HCBS gaps for these enrollees. For example, **Tennessee** has established coordination and care transition requirements for FIDE SNPs with exclusively aligned enrollment with TennCare LTSS CHOICES and Employment and Community First CHOICES Medicaid plans. FIDE SNPs must provide Medicare and Medicaid care coordination through a single point of contact. For enrollees receiving LTSS, Tennessee encourages plans to use the state's health information exchange so Medicare and Medicaid providers can access the enrollee's person-centered support plan, as appropriate. Plans must also have processes in place for ongoing information exchange among nursing facilities, HCBS providers, and primary care and behavioral health providers.

  While many states set requirements for information sharing, implementation and monitoring of these requirements can be challenging. For example, CHCS' state advisory panel participant from **Ohio** noted that care transition communication is straightforward for individuals enrolled in the state's FIDE SNPs. However, it is much more challenging for the state to monitor information sharing for CO D-SNP enrollees who are not enrolled in an aligned MyCare Ohio Medicaid MCO. MyCare Ohio plans also have difficulty obtaining information on approved hours and care plans for new enrollees transitioning from the state's PASSPORT Medicaid HCBS waiver. PASSPORT enrollee data exported from the Ohio Department of Aging's information system must be manually converted into a different format before the state's D-SNPs can use it. To facilitate the transition of service delivery, the state has established a

six-month HCBS continuity of care requirement for new MyCare Ohio enrollees if their providers are outside of the plan's network.[100]

Panel members from **California** and **Pennsylvania** described similar oversight challenges. California has SMAC requirements for D-SNPs to coordinate with providers of Medicaid HCBS waiver services and state plan services delivered through the In-Home Supportive Services program. In practice, it can be challenging for D-SNPs and In-Home Supportive Services providers to establish working relationships that facilitate coordination. In Pennsylvania, information sharing between the state's D-SNPs and its Community HealthChoices Medicaid MLTSS plans is supported by data-sharing agreements. The state is also working to establish data-sharing agreements between D-SNPs and behavioral health MCOs.

STATE SPOTLIGHT **Pennsylvania's Care Coordination Requirements**

Pennsylvania has added SMAC care management requirements to strengthen information-sharing and care coordination between D-SNPs and the state's Community HealthChoices Medicaid MLTSS plans, which do not operate with exclusively aligned enrollment, and between D-SNPs and behavioral health MCOs. For full-benefit dually eligible enrollees, D-SNPs must notify Community HealthChoices service coordinators within 48 hours about: (1) planned or unplanned inpatient hospital or nursing facility admissions and discharges; (2) emergency department visits; (3) high-priority health concerns; (4) the availability of discharge planning documents; and (5) significant medication changes. D-SNPs may notify service coordinators by telephone, email, direct data exchange, or through one of the state's five Health Information Organizations (HIOs).

Pennsylvania also requires D-SNPs to report on care coordination activities and submit an annual improvement plan. Through these reports and other oversight activities, the state has identified opportunities for improving the timeliness and completeness of provider data reported through HIOs. Pennsylvania is working with the HIOs to address data gaps.

To further facilitate care coordination, state staff also convene quarterly meetings with D-SNPs, Community HealthChoices MLTSS plans, and behavioral health MCOs to share best practices and case examples, as well as address issues around coordinating care for enrollees.

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked enhancing communication as highly feasible for aligned D-SNPs and Medicaid MCOs. The panel also ranked this activity as having a significant benefit for D-SNP enrollees.

2. Encourage or require D-SNPs to offer supplemental benefits that support family caregivers.

- **Description**: States can use SMACs to encourage or require D-SNPs to offer supplemental benefits that support family caregivers or provide other LTSS-like services. These benefits can help dually eligible individuals remain in their homes and communities. Caregiver supports may include:[101]
  - Counseling around stress management, coping strategies, and behavior change;
  - Counseling to address feelings of isolation and loneliness;
  - Coaching, educational workshops, and stress management courses; and
  - Respite care, either through in-home or adult-day programs.

- **Considerations for Implementation:** Medicare Advantage plans, including D-SNPs, have historically been allowed to offer enrollees extra benefits such as dental, vision, and fitness services, but CMS required these supplemental benefits to be "primarily health-related."[102,103] In 2019, CMS broadened its interpretation, allowing plans to cover a wider array of benefits, including LTSS-like services such as adult day health, in-home personal care, and support for family caregivers.[104] In addition, beginning in 2020, CMS also allowed plans to offer Special Supplemental Benefits for the Chronically Ill (SSBCI) to enrollees with select chronic conditions.[105] SSBCI can be nonmedical benefits if they can enhance or preserve an enrollee's health or overall functional capacity.[106]

  Since CMS provided these added flexibilities, more Medicare Advantage plans — particularly D-SNPs — have begun offering these benefits.[107] For example, 24 percent of all D-SNPs offer caregiver supports as supplemental benefits in 2026.[108]

  Other supplemental benefits may also help family caregivers. In 2026, D-SNPs are offering food and produce benefits (89 percent), non-medical transportation (44 percent), and in-home support services (29 percent).[109]

  States increasingly require D-SNPs to offer specific supplemental benefits. Early requirements focused on more traditional items, like dental and vision services, while states are now asking D-SNPs to provide benefits that support caregivers as well. Examples from 2027 SMACs include requirements to cover non-emergency medical transportation (**Louisiana**), personal emergency response systems and post-acute meal services (**Nevada**), benefits that complement Medicaid LTSS (**Michigan**), and respite care (**Ohio**).[110] States can work with D-SNPs to identify required benefits and approaches that ensure access to these benefits.

STATE SPOTLIGHT **Ohio FIDE SNP Supports for Family Caregivers**

In Ohio, FIDE SNPs are aligned with MyCare Ohio MLTSS plans. Beginning in 2027, the state will require FIDE SNPs to offer at least 40 hours of respite care annually as a supplemental benefit for caregivers of enrollees in a MyCare Ohio HCBS waiver program. The requirement is intended to reduce caregiver burden and help enrollees remain in their homes. Ohio also requires FIDE SNPs to offer other supplemental benefits, such as community-based palliative care and nonemergency medical transportation, that can also support family caregivers.

These benefits are part of a broader approach that recognizes the role of family caregivers in supporting enrollees in integrated FIDE SNP/MyCare Ohio plans. FIDE SNP assessments must identify enrollees' formal and informal supports and caregivers' status and capabilities. Plans must account for changes in caregiver status and support in enrollee risk stratification. Similarly, enrollees' person-centered plans of care must also be developed and updated with input from the enrollee, their family, and caregivers.

Ohio is one of a small number of states that cover Structured Family Caregiving (SFC) for older adults and people with disabilities through Medicaid HCBS waiver programs. SFC includes an array of services that support the primary caregivers of Medicaid HCBS waiver enrollees. SFC allows enrollees to hire family members as paid caregivers and provides caregivers with training based on the enrollee's specific needs, coaching, backup or respite care, and other supports. Ohio requires FIDE SNPs to work with designated SFC agencies that deliver caregiver support, training, and education and oversee and reimburse live-in caregivers for personal care services.

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked this action as moderately feasible and likely to provide some benefit to D-SNP enrollees.

Tools and Resources for States

- **Leveraging Dual Eligible Special Needs Plan (D-SNP) Models of Care to Enhance Enrollee Care Coordination**. This webinar provides an overview of federal D-SNP care coordination and MOC requirements and describes state options for incorporating care coordination requirements into SMACs with D-SNPs. *(Integrated Care Resource Center, April 2023)*
- **Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations**. This brief examines approaches used by Oregon, Pennsylvania, and Tennessee to develop and implement D-SNP information-sharing processes that support care transitions. *(Integrated Care Resource Center, August 2019)*
- **Sample SMAC Language – Optional Elements for All D-SNPs**. This resource provides sample contract language for care coordination and other optional SMAC provisions that states may choose to advance their goals. *(Integrated Care Resource Center, January 2025)*
- **Health Plan Perspectives on Using Medicare Advantage Supplemental Benefits to Support Family Caregivers**. This blog post examines the value of supporting family caregivers and highlights how two D-SNPs designed and delivered caregiver benefits. *(CHCS, January 2022)*
- **Supporting Family Caregivers**. This *Evidence-to-Action Collection* shares summaries of evidence on programs that support family caregivers and offers tools and case studies to inform implementation. *(CHCS, August 2025)*
- **Medicare Caregiver Training Services Reimbursement**. This *Evidence-to-Action Roundup* connects evidence and implementation resources with emerging state and federal policies around new opportunities to provide training for caregivers of Medicare beneficiaries, including dually eligible individuals. *(CHCS, July 2024)*

MODULE 4

Improving Care Coordination and Reducing Fragmented Care

People who are dually eligible for Medicare and Medicaid often have complex and intersecting needs, including multiple chronic physical and behavioral health conditions, functional limitations that may require LTSS, and health-related social needs such as food, transportation, and housing. They must also navigate two distinct programs with different benefits, eligibility rules, and administrative processes. As a result, dually eligible individuals and their caregivers may experience fragmented and uncoordinated care, resulting in delayed services and poor care experiences and outcomes.

Effective care coordination helps address these challenges by connecting individuals to covered benefits and community-based resources, facilitating communication across providers and payers, supporting person-centered care planning, and helping enrollees understand and act on their care options. However, access to meaningful, high-quality care coordination is uneven.

To improve care coordination and reduce fragmentation of care, states can take steps to strengthen care coordination processes, improve communication, and ensure that care coordination is person-centered and culturally appropriate.

This toolkit module summarizes feedback from dually eligible individuals about their care coordination experiences and outlines potential actions states can take to apply that feedback to policy decisions, program design, and operational processes.

What Do Dually Eligible Individuals Say?

Published literature and CHCS' advisory panel of dually eligible individuals suggest that relatively few enrollees in integrated care programs report consistent access to care coordination. Enrollees want a larger role in setting their goals and developing their care plans, as well as more help navigating benefits and connecting with providers and resources. Some also report that their care is not person-centered or culturally appropriate. This section examines these themes in more detail.

Care Coordinator Relationships

Care coordination is central to integrated care programs for dually eligible individuals. However, not all integrated care program enrollees know who their care coordinator is, meet with their coordinator regularly, or understand how their care coordinator can support them.[111,112] Health plans may not clearly distinguish care coordinators from other health plan or provider staff performing similar roles. For example, care coordinators may introduce themselves to enrollees by name or as health plan representatives, rather than explicitly as care coordinators.[113] In one study interviewing D-SNP enrollees, participants were initially uncertain whether they had a care coordinator. After reviewing descriptions of what care coordinators do (e.g., assisting with respite and home health care needs, getting food support, clarifying medical bills, and requesting medical equipment), many recognized someone who played that role in their care.[114] However, some study participants reported having a care coordinator but not receiving the full range of listed services.[115]

Plan type and care complexity may also affect whether enrollees know they have a care coordinator. In Medicaid and CHIP Payment and Access Commission (MACPAC) focus groups, all participants enrolled in **New York State's** Fully Integrated Duals Advantage demonstration for people with intellectual or developmental disabilities or **Washington State's** Financial Alignment Initiative

demonstration reported having a care coordinator.[116] In contrast, among those enrolled in less-integrated, CO D-SNPs, fewer than half in **South Carolina** reported having a care coordinator, while about half in **Texas** and New York did.[117,118]

Enrollees in integrated care programs report mixed experiences with care coordination processes. In evaluations of demonstrations under the federal Financial Alignment Initiative, enrollees who reported receiving care coordination services tended to view their experiences in these programs positively.[119,120] In focus groups conducted as part of these evaluations, many participants said their care coordinators improved coordination across providers and access to needed services.[121] In another study, demonstration enrollees appreciated their care coordinators' outreach and responsiveness and believed the care coordinators cared about their needs.[122] However, many D-SNP enrollees in MACPAC's focus groups said care coordination provided little benefit.[123]

Frequency and Consistency of Care Coordinator Contact

For dually eligible individuals in integrated care programs, the frequency and consistency of interactions with care coordinators greatly influenced their care experiences. Early in the demonstrations under the Financial Alignment Initiative, Medicare-Medicaid Plans rapidly enrolled new members and expanded care coordination staffing. Some demonstration enrollees said their care coordinators managed large caseloads, which they believed limited follow-up and connection to needed services.[124,125] Other demonstration enrollees reported high turnover among their care coordinators.[126,127] People who lost a care coordinator expressed frustration with having to repeatedly describe their health conditions and needs to multiple new coordinators and would have preferred one consistent care coordinator.[128] A case study of one demonstration program noted that enrollees valued a personal connection with their care coordinator and benefited from ongoing monitoring of their health needs and changes in their condition over time.[129] This study suggested that improving care coordinator consistency and retention could improve enrollee satisfaction.[130]

Care coordinator turnover can also disrupt care experiences. In one focus group study, younger dually eligible individuals with disabilities said turnover forced them to repeatedly rebuild relationships and restart the care planning process.[131] These focus group participants said they could not rely on care coordinators to advocate for them, and, instead, had to manage their own care needs despite their complex circumstances.[132] Other studies found that inconsistent contact left D-SNP enrollees feeling they are not getting the personal care and attention they deserve,[133] or sufficient value from their health plan.[134,135]

Experiences with Health Risk Assessments, Goal Setting, and Care Planning

Care coordination includes activities such as assessing an enrollee's goals and needs, developing an individualized care plan in consultation with the enrollee, and using an interdisciplinary team to help enrollees navigate care and address their needs.[136]

While D-SNPs are required to conduct assessments and develop care plans for every enrollee — as were the demonstrations under the Financial Alignment Initiative — enrollees' memories of and experiences with these care coordination processes were mixed. Some demonstration enrollees indicated that assessments occurred regularly and they had a care plan that their care coordinator revisited periodically, which can help keep services aligned with enrollees' changing needs and

preferences. Other enrollees described more sporadic interactions with care coordinators, potentially limiting opportunities to review and update their care plans.[137,138,139]

Dually eligible individuals also report mixed feedback about their experiences with goal setting. In the demonstrations under the Financial Alignment Initiative, some enrollees reported positive experiences with goal setting, describing both participating in setting goals and getting help achieving their goals.[140] However, other demonstration enrollees said they were not asked about their health-related goals and no one worked with them to achieve those goals.[141] Goal setting and care plan development should ideally be done in consultation with enrollees so they reflect enrollees' needs and priorities. However, this does not always occur. One member of CHCS' enrollee advisory panel said, "I had a negative experience with a care plan. I was forced to complete one when being assigned to a new psychiatrist and it wasn't done in partnership and was not patient centered."

Navigating and Accessing Benefits

Navigating overlapping Medicare and Medicaid benefits can be challenging, particularly for dually eligible individuals who often have complex health and social support needs. In integrated care programs, health plan care coordinators — or dedicated care navigators in some programs — help enrollees understand their benefits and connect them to needed care and resources.

In one study that interviewed dually eligible individuals, few mentioned using their health plan's navigator, while others said a care navigator had not contacted them or that they had to initiate contact when they needed assistance.[142] Other studies found that dually eligible individuals sought information about navigating coverage and accessing benefits from trusted sources outside their health plans, including advocacy organizations and ADRCs, because they view these sources as unbiased.[143,144]

Health plan processes for requesting help or information can also place a substantial burden on dually eligible individuals. One study reported that **dually eligible individuals spent considerable time calling plans and waiting to receive information**, yet did not always get the support they needed.[145] Participants also spent additional time researching providers and benefits, emphasizing that this self-advocacy was critical to getting the care they need.[146] A member of CHCS' advisory panel of dually eligible individuals agreed with this sentiment, saying, "I have learned that I'm the go-between and that seems to be pretty common. I am always the one navigating my care."

Language Access and Cultural Competence

Dually eligible individuals come from diverse backgrounds, making language accessibility and culturally competent care essential.[147] In evaluations of the demonstrations under the Financial Alignment Initiative, Spanish-speaking enrollees, despite reporting overall positive experiences with their Medicare-Medicaid Plans, reported less communication and care coordination than English-speaking enrollees.[148] Although these demonstration programs were required to provide bilingual staff or translation services, Spanish-speaking enrollees generally reported weaker connections with their care coordinators and more barriers to accessing key resources compared to English speakers.[149]

The demonstration evaluations also highlighted a need for cultural competence supports. Several focus group participants said **care coordinators should receive training to understand cultural preferences**, for example, around discussing certain medical procedures and end-of-life planning.[150]

State Actions in Response to Feedback

States can use their D-SNP contracts to improve care coordination and reduce the care fragmentation experienced by enrollees. States that enroll their dually eligible populations in Medicaid managed care programs may have additional opportunities to support aligned care coordination. States without Medicaid managed care or with only CO D-SNPs can also take steps to improve coordination.

CHCS' state advisory panel rated three potential actions based on their feasibility and potential impact:

1. Require specific care coordination processes for high-risk enrollees.

- **Description**: States can require D-SNPs to employ specific care coordination processes for one or more well-defined high-risk groups to strengthen care coordination and help ensure that integrated care programs provide value for dually eligible individuals with greater needs.
- **Considerations for Implementation**: CMS requires all D-SNPs to meet certain care coordination requirements, including:[151]
  - Conducting an initial and annual health risk assessment (HRA) to assess enrollees' physical, psychosocial, and functional needs as well as a limited range of health-related social needs (food, transportation, and housing);
  - Developing and implementing individualized care plans for each enrollee;
  - Using interdisciplinary care teams to address enrollees' health and functional needs; and
  - Using an approved MOC to ensure an effective care management structure.

  In addition, CMS requires CO D-SNPs to share information with the state or its designee when members of a designated high-risk group of full-benefit dual eligible individuals are admitted to a hospital or SNF.[152] This information can help the state Medicaid agency, or another entity such as a Medicaid MCO or Medicaid waiver case management entity, better coordinate enrollees' care transitions and access to needed Medicaid services.

  States can add care coordination requirements to their SMACs beyond the minimum activities required by CMS. Some states use these requirements to focus on specific high-risk populations of dually eligible individuals. For example, **California** requires its D-SNPs to include Dementia Care Specialists — care coordinators with specialized training in Alzheimer's disease and related dementias — in care teams and encourage their network primary care providers to use Dementia Care Aware resources[153] to identify cognitive impairment. **Hawaii** requires its D-SNPs to identify enrollees who are also enrolled in the state's Medicaid 1915(c) waiver program for individuals with I/DD, which is administered by the Developmental Disabilities Division within the state's Department of Health. The individual's D-SNP care coordinator is the designated point of contact, and the D-SNP must provide the care coordinator's contact information to the Developmental Disabilities Division to share with the enrollee's I/DD waiver case manager to support information sharing and coordination across services.

Many states do not identify a specific high-risk group for CO D-SNP information-sharing requirements. Instead, they require plans to share hospital and SNF admission information for every full-benefit dual eligible enrollee. Some states target information sharing to more specific groups. **Nevada** requires D-SNPs to share admissions information on enrollees who are also enrolled in a Medicaid HCBS waiver.[154] More specific targeting may allow states to focus their care coordination resources on the highest-need D-SNP enrollees and may be easier for a state to monitor compliance and track enrollee outcomes.

STATE SPOTLIGHT **Indiana's D-SNP Dementia-Related Care Coordination Requirements**[155]

Indiana has added care coordination requirements for individuals with a dementia diagnosis to its D-SNP SMACs. Requirements cover different aspects of care coordination:

- **MOC requirements:** In their MOCs, D-SNPs must describe the characteristics of their enrollee populations with a dementia diagnosis as well as how they identify enrollees living with dementia and their caregivers. MOCs must also include all written care coordination policies for enrollees with a dementia diagnosis.
- **Dementia care program:** D-SNPs must work with the state to develop dementia care education and support programming for all D-SNP enrollees with a dementia diagnosis and their caregivers. D-SNPs must provide a Dementia Caregiver Support Program to caregivers of enrollees with a dementia diagnosis who are not enrolled in the Medicaid HCBS waiver using the state's modified Guiding an Improved Dementia Experience (GUIDE) model requirements for ongoing caregiver education and support (GUIDE Domain 8).[156,157]
- **Designated care coordinator:** D-SNPs must assign a designated care coordinator for all enrollees with a dementia diagnosis to provide longitudinal care coordination and serve as the enrollee's point of contact in care transitions. D-SNPs must also make good faith efforts to enroll these individuals in care coordination.
- **Care coordinator training:** D-SNPs must train care coordinators on dementia care and on how to educate caregivers of enrollees with a dementia diagnosis.
- **LTSS referral:** For D-SNP enrollees with a dementia diagnosis who are not currently receiving Medicaid LTSS, the D-SNP must offer to refer the individual and/or their caregiver to the appropriate AAA within seven calendar days to connect the enrollee with local community resources and access to non-institutional LTSS.
- **Medication review:** For D-SNP enrollees with a dementia diagnosis who are also enrolled in one of the state's Medicaid HCBS waivers, the D-SNP must provide an annual comprehensive medication review that is conducted by a pharmacist working in collaboration with the D-SNP enrollee's care coordinator and prescribers. The medication review must include a medication action plan, personal medication list, summary of recommendations, and medication refill reminders.

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked requiring specific SMAC care coordination processes for high-risk enrollees as a highly feasible way to improve care coordination and reduce care fragmentation. The panel also ranked this activity as having a significant benefit for D-SNP enrollees.

2. Integrate care coordination across D-SNP, Medicaid MCO, and Medicaid waiver case management entities.

- **Description**: States can integrate the care coordination processes of D-SNPs and Medicaid MCOs or Medicaid waiver case management entities to create a more coordinated and integrated experience for enrollees.
- **Considerations for Implementation**: FIDE SNPs and HIDE SNPs, particularly those with exclusively aligned enrollment, can share information and coordinate care more seamlessly for their enrollees.

  States can use SMAC requirements to strengthen coordination between D-SNPs and Medicaid care coordination entities. **Indiana** requires its D-SNPs to assign a designated care coordinator to enrollees who are also enrolled in a Medicaid HCBS waiver. D-SNP care coordinators work with the enrollee's waiver service coordinator, who is a member of the enrollee's D-SNP interdisciplinary care team, to provide ongoing care coordination. In addition, the enrollee's waiver service plan is incorporated into their D-SNP individualized care plan. To support implementation of these requirements, the state facilitates D-SNP access to waiver service coordinator contact information and waiver service plans.[158]

  Washington State requires D-SNPs and Medicaid MCOs to have aligned provider networks and claims coordination processes.[159] The state also has specific SMAC and MOC care coordination requirements for people receiving LTSS and those with significant behavioral health needs. D-SNPs must report enrollee hospital and SNF admissions, and participate in meetings, held at least every two weeks, with long-term care system staff to coordinate care of hospitalized enrollees. Washington State developed an LTSS training that D-SNP staff and brokers must complete, and its website offers training and resources for plans, long-term care providers, and AAAs.

  Of note, CMS supports increased coordination between D-SNPs and Medicaid MCOs. Beginning in 2027, CMS will require applicable integrated plans — FIDE SNPs, HIDE SNPs, and some CO D-SNPs with exclusively aligned enrollment — to conduct integrated HRAs for enrollees, rather than separate Medicare and Medicaid assessments.[160] As one member of CHCS' state Medicaid advisory panel put it, "Truly integrating these [D-SNP and Medicaid] processes with the HRA will prevent duplicating documents, avoid asking the member the same questions multiple times, and result in a truly integrated care plan in one spot. Learning about the MOC and the D-SNP HRA is a great first step for states; then, asking how that differs from their own requirements guides how the two pieces fit together."

STATE SPOTLIGHT **Hawaii's Integrated Care Coordination Requirements**

For full-benefit dually eligible individuals, Hawaii requires the use of a single care coordinator across the FIDE SNP and their aligned Medicaid MCO. If an enrollee is also enrolled in the state's Medicaid I/DD waiver or its Community Care Services program for individuals with serious mental illness, the FIDE SNP care coordinator must also communicate with the respective care coordinators in those programs to facilitate information sharing and coordinate services. Hawaii requires that its FIDE SNP use an integrated HRA that incorporates the social risk factor screening questions included in the state's Medicaid managed care assessment.

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked integrating D-SNP and Medicaid MCO care coordination processes as a very feasible way to improve care coordination and reduce fragmentation of care. The panel also ranked this activity as having a significant benefit for D-SNP enrollees.

3. Support development of health plan processes and programs that are culturally competent and person-centered.

- **Description**: States can support the development of health plan processes and programs that are culturally competent and person-centered to build enrollees' trust in integrated care programs, promote enrollee engagement with health plans and providers, and improve enrollee experiences of care and care outcomes.

- **Considerations for Implementation**: Dually eligible populations include individuals from diverse backgrounds. They are more likely to be from a minority race or ethnic group (48 percent) than Medicare-only beneficiaries (22 percent).[161] Additionally, dually eligible individuals are more likely than Medicare-only beneficiaries to have limited English proficiency (17 percent versus two percent).[162] Because of program eligibility criteria, a significant proportion of dually eligible individuals have a physical or mental health disability.[163] Because of these and other identities, dually eligible individuals may face interpersonal and systemic discrimination and other structural barriers related to these identities. These barriers can affect access to care, trust in and engagement with health plans and providers, and care experiences and outcomes.

  States can support the development of D-SNP processes and programs that are culturally competent and person-centered. For example, **Ohio** requires its D-SNPs to ensure that services are delivered in a culturally appropriate manner by promoting cultural humility at all levels within the organization. D-SNPs must also train their member service representatives who answer enrollees' calls to understand and demonstrate sensitivity to cultural needs, including the disability culture and independent living philosophy.

- **Feasibility and Potential Impact**: CHCS' state advisory panel ranked supporting development of health plan processes and programs that are person-centered and culturally appropriate as a moderately feasible way to improve care coordination and reduce fragmentation of care. The panel also ranked this activity as potentially having a moderate benefit for D-SNP enrollees.

Tools and Resources for States

- **Leveraging Dual Eligible Special Needs Plan (D-SNP) Models of Care to Enhance Enrollee Care Coordination**. This webinar describes strategies states can use to improve care coordination for D-SNP enrollees, federal D-SNP care coordination and MOC requirements, state options for incorporating care coordination requirements into SMACs, and key considerations for states when implementing state-specific care coordination requirements. *(Integrated Care Resource Center, April 2023)*
- **How Can Integrated Care Programs More Effectively Coordinate Care for Dually Eligible Individuals?** This blog post highlights the importance of effective care coordination in improving outcomes for dually eligible individuals and how states can address gaps between federal expectations and state-level realities around care coordination, with a particular focus on D-SNPs. *(Health Affairs, December 2023)*
- **Care Coordination for D-SNP State Medicaid Agency Contracts**. This toolkit provides policymakers with principles and template language for developing care coordination requirements in D-SNP contracts that respond to the needs of dually eligible populations. *(Justice in Aging, August 2025)*
- **How Integrated Programs Can Address the Challenges of Limited English Proficiency for Dual Eligible Individuals**. This blog post describes how state policymakers can improve person-centered care for dually eligible individuals with limited English proficiency and their caregivers using D-SNP and Medicaid managed care contracts and state guidance. *(Health Affairs, January 2024)*

Conclusion

Advancing Medicare-Medicaid integration often requires state policymakers and agency staff to manage complex day-to-day operational demands, including federal rules and guidance, health plan contracts and oversight, and implementation deadlines. While these details are important, it is also essential for states to assess whether their programs are working for the people they serve. This toolkit highlights practical actions states can take to ensure their integrated care programs align with the goals and needs of dually eligible populations.

Medicaid policy and budget pressure can make it challenging for states to design and implement integrated care programs. Despite this, many states are investing in these models because they offer a promising way to address fragmented and uncoordinated care, which can create systemic inefficiencies, increase costs, and contribute to poor care experiences and outcomes.

This toolkit incorporates the perspectives of dually eligible people drawn from a review of published studies and a national advisory panel. States can build on these insights by seeking feedback from dually eligible individuals in their own states and local communities to inform policies and practices. Direct engagement with enrollees can provide policymakers and other state officials with a valuable reality check and help ensure that program decisions reflect enrollees' priorities.

Appendix

1. Daily Life

- Caregivers (Formal or Informal)
- Elder Abuse/Neglect
- Family Relationships/Dynamics
- Food and Nutrition Services
- Isolation
- Learning
- Mentorships or Partnerships
- Pets
- Routines and Activities
- Adult Day Care/Senior Community Centers
- Sexual Activity
- Social Services and Programs
- Friendships/Social/Community Relationships
- Technology
- Driving/Transportation
- Living with Disabilities

2. Finances

- Assets
- Employment: Desire to Work, Past Employment, Job History
- Money: Preparedness, Management, Wealth Status
- Fraud and Financial Literacy
- Out-of-Pocket Costs
- Non-Medical Insurance
- Retirement: Status, Pension, Social Security Benefits

3. Health and Well-Being

- Durable Medical Equipment and Supplies
- Managing Acute or Chronic Health Conditions
- Cognitive Ability
- End-of-Life
- Exercise
- Health Attitudes and Perception
- Managing Mental Health Conditions
- Physical Capacity and Mobility
- Physical Safety
- Prevention and Contributors to Health or Wellness
- Substance Use

4. Health Insurance

- Medicaid
- Medicare
- Beneficiary Knowledge and Information Needs
- Drug Coverage
- Federal/State/Union Insurance
- Benefits Navigation Support
- Health Care Costs
- No Insurance
- Military/Veteran Insurance
- Non-Medical Benefits
- Health Plan Choice
- Private/Supplemental Insurance
- Eligibility and Enrollment

5. Health Care

- Access to Care
- Dental, Vision, and Hearing Care
- Medication Side Effects
- Health Care Experiences
- Health Care Usage
- Holistic Care
- Long-Term Services and Supports
- Medical Discrimination
- Pharmacies
- Physical Therapy
- Primary Care
- System Integration and Fragmentation
- Trust/Satisfaction with Care

6. Housing and Home

- Aging in Place
- Changing Home Needs/Home Features/Home Modifications
- Geography
- Home Ownership
- Household Members
- Housing Assistance
- Housing Security/Stability/Experience
- Residential Care Setting

7. Personal Story and Identity

- Ageism
- Control and Autonomy
- Cultural Competence, Language, and Provider Preferences
- Early Life
- Gender
- Hopes for the Future, Life/Aging Priorities/Fulfillment/Purpose
- Immigration
- Mindsets and Worldviews
- Prior Expectations of Aging
- Race and Ethnicity
- Racism
- Religion
- Self-Advocacy
- Sexual Orientation/Sexuality

8. Policymaking and Innovation

- Attitudes Toward Policymaking and Systems
- Pilots and Policies
- Policymaking and System Improvement Challenges or Opportunities
- Recommendations/Considerations for States

ENDNOTES

[1] Hafner, M., Farrar, B., Johnson, K., Pedersen, S., Allen, K., Fish, T., & Pirzada, F. (2021, August). *Using human centered design to understand the experiences of dually eligible individuals: Lessons from lived experience* [Report]. AIR/Arnold Ventures. https://www.air.org/sites/default/files/2022-06/Human-Centered-Design-Approach-to-Duals-508.pdf

[2] Brand, M., Cohen, M., & Tell, E. (2024, January). *Centering perspectives of dually eligible older adults of color: Piloting co-creation of home and community-based care quality measures* [Report]. Community Catalyst. https://communitycatalyst.org/wp-content/uploads/2024/02/Centering-Perspectives-of-Dually-Eligible-Older-Adults-of-Color.pdf

[3] Medicare Rights Center. (2024, September). *Challenges faced by dual eligibles* [Case studies]. https://www.medicarerights.org/policy-documents/msp-enrollment

[4] Lyons, B., & Andrews, J. (2025, February*). Improving Medicare–Medicaid integration: Priorities of dual-eligible adults under age 65* [Brief]. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/feb/improving-medicare-medicaid-integration-dual-eligible-under-65

[5] Summer, L., O'Malley Watts, M., & Musumeci, M. (2015, August). *Dual eligible demonstrations: The beneficiary perspective* [Brief]. Kaiser Family Foundation (KFF). https://www.kff.org/medicaid/dual-eligible-demonstrations-the-beneficiary-perspective/

[6] Freed, M., Cottrill, A., Fuglesten Biniek, J., & Neuman, T. (2023, September). *What do people with Medicare think about the role of marketing, shopping for Medicare options, and their coverage?* [Report]. KFF. https://www.kff.org/medicare/what-do-people-with-medicare-think-about-the-role-of-marketing-shopping-for-medicare-options-and-their-coverage/

[7] Kogan, R., Chelminsky, D., Heitkamp, S., Hossen, S., Jacobs, D., Spiering, M., Fernandez, K., & Bush, C. (2024, September). *The Dual Eligible Terms and Experience Study: Summary report – Findings from user testing and formative research in Minnesota and Arizona* [Report]. Mathematica. https://www.cms.gov/files/document/2024detestudysummaryreport-azmn.pdf

[8] Ruggeri, S. (2023, July). *Policy options to create a person-centered enrollment infrastructure for Medicare-Medicaid enrollees* [Report]. Community Catalyst. https://communitycatalyst.org/resource/policy-options-to-create-a-person-centered-enrollment-infrastructure-for-medicare-medicaid-enrollees/

[9] ATI Advisory. (2023, August). *Beneficiary protections central to a meaningfully integrated coverage and care experience for individuals who are dual eligible* [Brief]. https://atiadvisory.com/resources/beneficiary_protections_ati_arnold-pdf/

[10] A D-SNP is a type of Medicare Advantage plan that only enrolls dually eligible individuals and is specifically designed to meet their needs.

[11] Kogan, et al., 2024, September.

[12] McBride, K., Bacon, A. M., Reynoso, A., Benjamin, A. E., Wallace, S. P., & Kietzman, K. G. (2019). Healthcare decision-making among dual-eligible immigrants: Implications from a study of an integrated Medicare–Medicaid demonstration program in California. *Journal of Immigrant and Minority Health*, 22(3), 494–502. https://link.springer.com/article/10.1007%2Fs10903-019-00922-5

[13] Hafner, et al., 2021, August.

[14] Ruggeri, 2023, July.

[15] Summer, et al., 2015, August.

[16] Lind, A., Bittinger, K., Xiao, Y., Rogers, J., Beals, M., Means, K., Shults, J., & Mancuso, D. (2024, July). *Navigating Dual Eligibility: A survey of dually enrolled Medicare and Medicaid beneficiaries* [Report]. Washington State Department of Social and Health Services Research and Data Analysis Division. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-9-127.pdf

[17] Freed, et al., 2023, September.

[18] Freed, et al., 2023, September.

[19] McBride, et al., 2019.

[20] McBride, et al., 2019.

[21] ATI Advisory, 2023, August.

[22] In some areas, SHIPs may be called Statewide Health Insurance Benefits Advisors (SHIBA), Serving the Health Insurance Needs of Everyone (SHINE), or the Health Insurance Counseling & Advocacy Program (HICAP).

[23] Freed, et al., 2023, September.

[24] NORC at the University of Chicago. (2025, June). *Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2025 focus groups in St. Louis, Missouri, and 2021–2025 rural focus groups* [Report]. Medicare Payment Advisory Commission (MedPAC). https://www.medpac.gov/wp-content/uploads/2025/07/Jun25_MedPAC_FocusGroupSiteVisitReport_CONTRACTOR_SEC.pdf

[25] Lind, et al., 2024, July.

[26] Ruggeri, 2023, July.

[27] Trish, E., Valdez, S., Ginsburg, P. B., Randall, S., & Lieberman, S. M. (2023). Substantial growth in Medicare Advantage and implications for reform. *Health Affairs, 42*(2), 246–251. https://doi.org/10.1377/hlthaff.2022.00668

[28] NORC at the University of Chicago, 2025, June.

[29] Freed, et al., 2023, September.

[30] NORC at the University of Chicago, 2025, June.

[31] Lyons & Andrews, 2025, February.

[32] Kogan, et al., 2024, September.

[33] Summer, et al., 2015, August.

[34] NORC at the University of Chicago, 2025, June.

[35] ATI Advisory, 2023, August.

[36] Tennessee Department of Finance and Administration, Division of TennCare. (n.d.). *Dual eligible special needs plan (D-SNP)* [webpage]. https://www.tn.gov/tenncare/long-term-services-supports/dual-eligible-special-needs-plan--d-snp-.html

[37] Tennessee Department of Finance and Administration, Division of TennCare. (n.d.). *TennCare dual eligible special needs plan (D-SNP)* [Brochure]. https://www.tn.gov/content/dam/tn/tenncare/documents/DSNPbrochure.pdf

[38] Personal communication with staff from Virginia's Department of Medical Assistance Services. June 18, 2026.

[39] Virginia Department of Medical Assistance Services. (n.d.). *Enrolling beneficiaries into Virginia dual eligible special needs plans* [Video]. https://www.youtube.com/watch?v=lcEIKSeRgTw

[40] ATI Advisory, 2023, August.

[41] Hafner, et al., 2021, August.

[42] Freed, et al., 2023, September.

[43] Lyons & Andrews, 2025, February.

[44] ATI Advisory, 2023, August.

[45] Hafner, et al., 2021, August.

[46] Huson, T., & Blom, K. (2023, March). *Focus group findings: Experiences of full benefit dually eligible beneficiaries in integrated care models.* Medicaid and CHIP Payment and Access Commission (MACPAC) [Slide deck]. https://www.macpac.gov/publication/focus-group-findings-experiences-of-full-benefit-dually-eligible-beneficiaries-in-integrated-care-models-2/

[47] Lyons & Andrews, 2025, February.

[48] Hafner, et al., 2021, August.

[49] Huson & Blom, 2023, March.

[50] Huson & Blom, 2023, March.

[51] Lyons & Andrews, 2025, February.

[52] Lyons & Andrews, 2025, February.

[53] Ptaszek, A., Chepaitis, A., Greene, A. M., Hoover, S., Khatutsky, G., Lyda-McDonald, B., Roberts, Q., Thach, N., Gattine, E., Holladay, S., & Tranfaglia, J. (2017, March). *Beneficiary experience: Early findings from focus groups with enrollees participating in the Financial Alignment Initiative* [Report]. Centers for Medicare & Medicaid Services (CMS). https://www.cms.gov/priorities/innovation/Files/reports/fai-focusgroup-issuebrief.pdf

[54] Huson & Blom, 2023, March.

[55] Lyons & Andrews, 2025, February.

[56] Lyons & Andrews, 2025, February.

[57] Rowan, P., Denny-Brown, N., Gupta, R., Bovat, S., & Jimenez, E. (2022, January). *Integrated appeals & grievances demonstration in New York: Beneficiary experience research* [Report]. Mathematica. https://www.mathematica.org/publications/integrated-appeals-and-grievances-demonstration-in-new-york-beneficiary-experience-research

[58] Rowan, et al., 2022, January.

[59] Ptaszek, et al., 2017, March.

[60] Hafner, et al., 2021, August.

[61] Hafner, et al., 2021, August.

[62] Hafner, et al., 2021, August.

[63] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. (2019, May). *Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications* [Brief]. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/189201/DualLoss.pdf

[64] CMS, Medicare-Medicaid Coordination Office. (2022, August). *Overview of loss of full-benefit dual eligibility, 2015-2018.* https://www.cms.gov/files/document/fullbenefitdualeligibilitylossoverview2015-2018.pdf

[65] Lyons & Andrews, 2025, February.

[66] ATI Advisory, 2023, August.

[67] Freed, et al., 2023, September.

[68] Freed, et al., 2023, September.

[69] CMS. (2025, August 1). *Medicare Advantage and Part D enrollment and disenrollment guidance* [Guidance]. https://www.cms.gov/files/document/cy-2026-cd-enrollment-and-disenrollment-guidance.pdf

[70] CMS. (2024, November). *Medicare managed care manual: Chapter 16-B: Special needs plans [Manual].* https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf

[71] Weir Lakhmani, E., Lomas, A., & Wood, E. (2022, March). *Preventing and addressing unnecessary Medicaid eligibility churn among dually eligible individuals: Opportunities for states* [Brief]. Integrated Care Resource Center. https://integratedcareresourcecenter.com/sites/default/files/ICRC-Addressing-Medicaid-Churn_3.pdf

[72] Weir Lakhmani, et al., 2022, March.

[73] 42 CFR 436.916(b)(2)(iii) notes that, when an individual finally does submit a renewal form or other needed information within the deeming period window, the state Medicaid agency must treat the renewal as a new application. As such, the One Big Beautiful Bill Act (P.L. 119-21) may limit the state from reinstating that individual's enrollment back by more than 60 days, and so the state may not be able to reimburse the health plan for expenses incurred beyond that 60 days.

[74] Integrated Care Resource Center. (2026, April). *Promoting provider network alignment to improve integration in D-SNPs.* https://integratedcareresourcecenter.com/webinar/promoting-provider-network-alignment-improve-integration-d-snps

[75] Ohio Department of Medicaid. (2026, January*). The Ohio Department of Medicaid Next Generation MyCare Ohio provider agreement for MyCare Ohio plan*. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/ProviderTypes/Managed%20Care/MyCareOhio/2026_01_Next_Gen_MyCare_Final_PA.pdf

[76] Ohio Department of Medicaid, 2026, January.

[77] 42 CFR 422.101(f)(1-3). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.101

[78] 42 CFR 422.562(a)(5)(i). https://www.ecfr.gov/current/title-42/section-422.562

[79] 42 CFR 422.101(f)(1-3).

[80] 42 CFR 422.562(a)(5)(i).

[81] For more information on what is included in the Model of Care, see: National Committee for Quality Assurance. *CY 2027 Scoring Guidelines, MOC 2: Care Coordination, Element C: Face to Face Encounter*. https://snpmoc.ncqa.org/scoring-guidelines-latest

[82] Tennessee Department of Finance and Administration, Division of TennCare. (2026). Contract with Volunteer State Health Plan, Amendment 2. Section 6.A.2.b.7.d-e. https://www.tn.gov/content/dam/tn/tenncare/documents2/VSHP78843.pdf

[83] Wolk, A., Ochieng, N., Fuglesten Biniek, J., & Burns, A. (2026, July). *A profile of dual-eligible individuals* [Fact sheet]. KFF. https://www.kff.org/medicare/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/

[84] Activities of daily living include bathing/showering, dressing, toileting, continence, transferring/ambulation, and eating.

[85] MedPAC & MACPAC (2025, December). *Data book: Beneficiaries dually eligible for Medicare and Medicaid* [Report]. https://www.macpac.gov/wp-content/uploads/2025/12/Dec25_MedPAC_MACPAC_DualsDataBook-WEB508-FINAL.pdf

[86] Stepanczuk, C., Carpenter, A., & Wysocki, A. (2024, July). *Characteristics of people using Medicaid long-term services and supports, 2021* [Report]. Mathematica. https://www.mathematica.org/publications/characteristics-of-people-using-medicaid-long-term-services-and-supports-2021

[87] Peebles, V., & Bohl, A. (2014, September 22). The HCBS taxonomy: A new language for classifying home- and community-based services. *Medicare & Medicaid Research Review, 4*(3), E1–E17. https://doi.org/10.5600/mmrr.004.03.b01

[88] NORC at the University of Chicago. (2026, March). *Home and community-based services landscape analysis & model case studies* [Report]. https://www.norc.org/content/dam/norc-org/pdf2026/hcbs-landscape-analysis-and-model-case-studies-final-report.pdf

[89] Burns, A., Wolk, A., O'Malley Watts, M., Mohamed, M., & Pena, M. (2024, October). *A look at waiting lists for Medicaid home- and community-based services from 2016 to 2024* [Fact sheet]. KFF. https://www.kff.org/medicaid/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/

[90] Lyons & Andrews, 2025, February.

[91] Brand, et al., 2024, January.

[92] Burns, A., Mohamed, M., & O'Malley Watts, M. (2023, October*). Payment rates for Medicaid home- and community-based services: States' responses to workforce challenges* [Brief]. KFF. https://www.kff.org/medicaid/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/

[93] Brand, et al., 2024, January.

[94] Ptaszek, et al., 2017, March.

[95] Community Catalyst & Lake Research Partners. (2017, March). *Experiences of consumers with managed long-term services and supports programs: Insights from dual eligible enrollees in Massachusetts and Ohio* [Report]. https://communitycatalyst.org/resource/experiences-of-consumers-with-managed-long-term-services-and-supports/

[96] National Academies of Sciences, Engineering, and Medicine. (2016). *Families caring for an aging America.* The National Academies Press. https://www.nationalacademies.org/read/23606/chapter/1#xii

[97] Lyons & Andrews, 2025, February.

[98] CMS. (2019, April 16). *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* [Federal Register]. https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

[99] Kruse, A., Archibald, N., & Lester, R. (2019, August). *Promoting information sharing by dual eligible special needs plans to improve care transitions: State options and considerations* [Brief]. https://integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions

[100] For individuals already residing in an out-of-network assisted living facility or nursing facility before enrolling in a MyCare Ohio plan, the plan must continue to pay the provider as long as the enrollee meets the level of care need and maintains dual eligible status. For more information on Ohio's continuity of care provision, see page 211 of the contract: 2026_01_Next_Gen_MyCare_Final_PA.pdf.

[101] Torralba, G., & Archibald, N. (2022, January 25). *Health plan perspectives on using Medicare Advantage supplemental benefits to support family caregivers* [Blog post]. CHCS Blog. https://www.chcs.org/health-plan-perspectives-on-using-medicare-advantage-supplemental-benefits-to-support-family-caregivers/

[102] These supplemental benefits are not available to individuals in Original Medicare.

[103] CMS. (2018, April 27). *Reinterpretation of "primarily health related" for supplemental benefits* [Health Plan Management System (HPMS) memo]. https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/hpms/hpms-memos-archive-weekly-items/syshpms-memo-2018-week4-apr-23-27

[104] CMS, 2018, April 27.

[105] CMS. (2019, April 24). *Implementing supplemental benefits for chronically ill enrollees* [HPMS memo]. https://www.cms.gov/medicare/health-plans/healthplansgeninfo/downloads/supplemental_benefits_chronically_ill_hpms_042419.pdf

[106] CMS, 2019, April 24.

[107] Mollitor, R., Cruse, C., & Sisto Gall, J. (2025, November). *CY2026 Medicare Advantage trends in nonmedical benefits* [Webinar]. https://atiadvisory.com/resources/wp-content/uploads/2025/11/ATI_CY26-MA-Trends-in-Nonmedical-Benefits.pdf

[108] ATI Advisory. (2026, February). *Medicare Advantage special needs plans* [Brief]. https://atiadvisory.com/resources/wp-content/uploads/2026/02/ATI_Medicare-Advantage-Special-Needs-Plans_Issue-Brief.pdf

[109] ATI Advisory, 2026, February.

[110] Personal communication with staff from Louisiana Department of Health. August 26, 2026, and Nevada Health Authority and Michigan Department of Health and Human Services. August 27, 2026.

[111] Kogan, et al., 2024, September.

[112] Kogan, et al., 2024, September.

[113] Kogan, et al., 2024, September.

[114] Kogan, et al., 2024, September.

[115] Kogan, et al., 2024, September.

[116] Huson & Blom, 2023, March.

[117] Coordination-only D-SNPs (CO D-SNPs) offer a lower degree of Medicare-Medicaid integration than either highly integrated D-SNPs (HIDE SNPs) or fully integrated D-SNPs (FIDE SNPs).

[118] Huson & Blom, 2023, March.

[119] Summer, et al., 2015, August.

[120] Huson & Blom, 2023, March.

[121] Ptaszek, et al., 2017, March.

[122] Beaver, D., Gringlas, R., Jacobs, D., Coy, L., & Baker, J. (2023, February*). Understanding the experiences of dually eligible beneficiaries enrolled in One Care* [Report]. Mathematica. https://www.mathematica.org/publications/understanding-the-experiences-of-dually-eligible-beneficiaries-enrolled-in-one-care

[123] Huson & Blom, 2023, March.

[124] Ptaszek, et al., 2017, March.

[125] Summer, et al., 2015, August.

[126] Ptaszek, et al., 2017, March.

[127] Whicher, D., Spiering, M., Beaver, D., Miller, F., & Gringlas, R. (2022, December). *Understanding the experiences of dually eligible beneficiaries enrolled in MI Health Link* [Report]. Mathematica. https://www.mathematica.org/publications/understanding-the-experiences-of-dually-eligible-beneficiaries-enrolled-in-mi-health-link

[128] Whicher, et al., 2022, December.

[129] Whicher, et al., 2022, December.

[130] Whicher, et al., 2022, December.

[131] Lyons & Andrews, 2025, February.

[132] Lyons & Andrews, 2025, February.

[133] Community Catalyst & Lake Research Partners, 2017, March.

[134] Huson & Blom, 2023, March.

[135] Hafner, et al., 2021, August.

[136] 42 CFR 422.101(f)(1-3).

[137] Ptaszek, et al., 2017, March.

[138] Huson & Blom, 2023, March.

[139] Beaver, et al., 2023, February.

[140] Ptaszek, et al., 2017, March.

[141] Ptaszek, et al., 2017, March.

[142] Hafner, et al., 2021, August.

[143] Lyons & Andrews, 2025, February.

[144] Whicher, et al., 2022, December.

[145] Hafner, et al., 2021, August.

[146] Hafner, et al., 2021, August.

[147] Benzing, L., Rizer, A., & Tumlinson, A. (2024, January 30). *How integrated programs can address the challenges of limited English proficiency for dual eligible individuals* [Blog post]. Health Affairs. https://www.healthaffairs.org/content/forefront/integrated-programs-can-address-challenges-limited-english-proficiency-dual-eligible

[148] Beaver, et al., 2023, February.

[149] Beaver, et al., 2023, February.

[150] Ptaszek, et al., 2017, March.

[151] Integrated Care Resource Center. (2023, April*). Leveraging dual eligible special needs plan (D-SNP) models of care to enhance enrollee care coordination* [Webinar]. https://integratedcareresourcecenter.com/webinar/leveraging-dual-eligible-special-needs-plan-d-snp-models-care-enhance-enrollee-care

[152] 42 CFR 422.107(d). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.107

[153] See: https://www.dementiacareaware.org/

[154] Personal communication with staff from Nevada Health Authority. August 27, 2026.

[155] Personal communication with staff from Indiana Family and Social Services Administration. August 28, 2026.

[156] For more information on the GUIDE model, see: https://www.cms.gov/priorities/innovation/innovation-models/guide

[157] For a description of GUIDE Domain 8, see: CMS, Center for Medicare & Medicaid Innovation. (2023, November 7). *Guiding an improved dementia experience* [Request for Applications]. Appendix B. https://www.cms.gov/files/document/guide-rfa.pdf

[158] Personal communication with staff from Indiana Family and Social Services Administration. August 28, 2026.

[159] Personal communication with staff from Washington State Department of Social and Health Services. August 25, 2026.

[160] 42 CFR 422.101(f)(1)(v). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.101

[161] CMS, Medicare-Medicaid Coordination Office. (2020, November). *Medicare-Medicaid dual enrollment 2006 through 2019* [Brief]. https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf

[162] Benzing, et al., 2024, January 30.

[163] MedPAC & MACPAC, 2025, December.