ICRC Integrated Care Resource Center

TIP SHEET

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Tips to Help States Select Medicaid Managed Care Authorities as They Design Integrated Care Initiatives for Dually Eligible Individuals

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Introduction

The federal Medicaid managed care operating authorities that states use to contract with Medicaid managed care plans or Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) can affect states' options for integrating Medicare and Medicaid benefits for dually eligible individuals. Similarly, the strategies states use for Medicare-Medicaid integration might also affect the Medicaid managed care authorities those states need to use when contracting with health plans to cover Medicaid benefits. Therefore, selecting an appropriate Medicaid managed care authority (or examining existing authorities) is a key step in designing new integrated care initiatives for dually eligible individuals. This Integrated Care Resource Center (ICRC) tip sheet describes two pathways states can use to offer integrated Medicare and Medicaid benefits through D-SNPs and the Medicaid managed care authorities states can use when adopting each pathway:

ICRC Resources on D-SNP Contracting

This tip sheet assumes that the reader already understands basic information about state contracting with D-SNPs. For more foundational resources on D-SNPs and D-SNP contracting, see this section of the ICRC website: https://integratedcareresourcecenter.com/resources-by-topic/dual-eligible-special-needs-plans

1. **Pathway 1:** Aligning D-SNPs with *affiliated Medicaid managed care plans* owned by the same parent company as the D-SNP
2. **Pathway 2:** *Contracting directly with D-SNPs* and paying them a per member per month rate to cover Medicaid benefits for D-SNP enrollees

This tip sheet summarizes key considerations for states trying to decide which pathway to use to advance Medicare-Medicaid integration, and which Medicaid managed care authority(ies) might best support that pathway. Although the tip sheet presents two pathways for states to consider, ultimately, a state may develop an integrated care model that falls somewhere in between these options. The Centers for Medicare & Medicaid Services (CMS) and ICRC can help each state identify a strategy that best meets its needs.

States can often use different authorities to achieve the same goal. The integrated care pathways and managed care authorities that states select depend on several factors, including the current managed care landscape in the state—specifically, whether the state has capitated Medicaid managed care programs, whether dually eligible individuals are currently enrolled in those programs, and whether dually eligible individuals' enrollment in those programs is voluntary or mandatory. Other considerations include the state's Medicaid managed care contract procurement timelines, and its priorities related to cost-effectiveness, comparability, and statewideness.

This tip sheet summarizes the four federal authorities available for implementing Medicaid managed care programs (**Box 1**) and provides tips on using these authorities in connection with integrated care programs. Selecting a Medicaid managed care operating authority is a complex process that requires states to analyze a variety of factors. Each state should carefully examine its own health care landscape, existing Medicaid authorities, and policy priorities, and consult with CMS to select an authority that best meets its needs.

Box 1. Key highlights of federal Medicaid managed care authorities for states integrating Medicare and Medicaid benefits for dually eligible individuals

Each authority has varying flexibilities and limitations that might be relevant when implementing integrated care programs for dually eligible individuals. For a more detailed summary of each authority, see **Appendix A**.

- **Section 1932(a) state plan amendment:** States can obtain indefinite approval of 1932(a) state plan amendments. States can also use these amendments to mandate managed care enrollment for some groups. However, managed care enrollment must be voluntary for dually eligible individuals. States may selectively contract with only certain health plans or contracted entities under this authority as long as a choice of at least two contracted entities is available in non-rural areas.
- **Section 1915(a) waiver:** States can implement voluntary Medicaid managed care programs through 1915(a) waivers. States that intend to allow dually eligible individuals to voluntarily enroll into a managed care program and do not plan to selectively contract with only certain plans may use the streamlined application for this waiver rather than filing a 1932(a) state plan amendment application, which is more detailed and requires the state to describe its selective contracting criteria. CMS can approve 1915(a) waivers for the length of the voluntary managed care contract.
- **Section 1915(b) waiver:** Under a 1915(b) waiver, states can mandate that dually eligible individuals enroll in Medicaid managed care plans and use selective contracting to restrict the number or qualifications of plans offered. States must renew a 1915(b) waiver every two to five years and demonstrate that programs authorized under 1915(b) are cost-effective and efficient.
- **Section 1115(a) demonstration:** States can use 1115(a) demonstrations to mandate that dually eligible individuals enroll in Medicaid managed care plans and to use selective contracting. States may receive additional matching funds during the demonstration period, but 1115(a) demonstrations must meet requirements for innovation and budget neutrality.

Key considerations for states in determining an integrated care pathway

The main consideration for states in deciding whether to use Pathway 1 or Pathway 2 is **whether the state has any existing capitated Medicaid managed care programs, and whether those programs serve dually eligible individuals.**

Most states have at least one type of Medicaid managed care delivery system, including programs that use comprehensive, risk-based managed care organizations (MCOs) and programs that involve limited-benefit plans, such as prepaid inpatient health plans and prepaid ambulatory health plans. Although 72 percent of Medicaid beneficiaries were enrolled in comprehensive Medicaid managed care plans nationwide in 2020, only about 30 percent of dually eligible individuals were enrolled in such programs that year.[1]

If a state has a Medicaid managed care program that enrolls dually eligible individuals, a straightforward approach to integrating Medicare and Medicaid benefits would be to use Pathway 1 and align D-SNPs with those existing plans. States can continue using the Medicaid managed care authorities already in place if they do not make changes to the pre-existing Medicaid managed care program that would be aligned with D-SNPs. If a state wishes to make changes to its Medicaid managed care program as part of its integrated care

strategy—for example, by covering new benefits or beginning to mandate enrollment for dually eligible individuals—it might need to request an additional authority or submit an amendment for an existing authority.

If a state does *not* already have a capitated Medicaid managed care program that serves dually eligible individuals, the state must determine whether it wishes to incorporate dually eligible individuals into a new or existing managed care program that it will align with D-SNPs (Pathway 1) or contract directly with D-SNPs to cover Medicaid benefits (Pathway 2). In deciding which pathway to use (or deciding to develop a model that combines both pathways), a state should consider a variety of factors, including the following:

1) **The state's current D-SNP landscape**, such as how many D-SNPs already operate in the state, which parent companies offer D-SNPs, and current D-SNP enrollment. States might also consider their existing relationships with D-SNPs, including the state's current contract requirements, communications, and data-sharing arrangements with D-SNPs, as well as the quality of care and enrollees' experiences with care, as demonstrated by D-SNPs' quality measure and member satisfaction ratings.
2) **The state's current resources and capacity for managed care rate-setting, contracting, and oversight.** States will need the actuarial capacity to set Medicaid capitation rates for benefits that are exclusively or primarily provided to dually eligible individuals through Medicaid, such as long-term services and supports (LTSS) and certain behavioral health services. States will also need the capacity to contract with Medicaid MCOs or D-SNPs for these Medicaid benefits and oversee their delivery.[2]
3) **Managed care procurement timelines.** States that intend to incorporate dually eligible individuals into an existing managed care program should consider the contracting and procurement cycle of that program in relation to their state's integration goals. If the steps a state needs to take to advance its integration strategy do not align with an upcoming procurement cycle, it can consider extending existing Medicaid MCO contracts or separately procuring affiliated Medicaid MCOs that will enroll dually eligible individuals.
4) **Other state goals outside of the integrated care initiative.** For example, states might already intend to launch a new Medicaid managed care program that enrolls dually eligible individuals, or they might wish to rebalance the delivery of LTSS away from traditional nursing facility services and toward more home and community-based services (see **Box 2** for information about incorporating LTSS into Medicaid managed care programs). States might be able to use these existing or forthcoming opportunities to design new programs and initiatives in ways that will simultaneously integrate Medicare and Medicaid benefits for dually eligible individuals. Indiana is an example of a state that has incorporated its plans for integrated care into its other state goals. See **Appendix B** for descriptions of how three states, including Indiana, have implemented integrated care programs using different pathways.
5) **The extent to which groups who would be affected by managed care might support or oppose a proposal to cover Medicaid benefits through D-SNPs or a new managed care program.** These groups might include dually eligible individuals and the advocacy organizations and health care providers that serve them, health plans, state legislators or other officials, or other interested parties. For example, recipients and providers of Medicaid LTSS and behavioral health services might be resistant to having those services provided through managed care, especially if the state provided them on a fee-for-service basis in the past.

Box 2. Incorporating LTSS into Medicaid managed care programs

States can also use Medicaid managed care authorities, either alone or in combination with other authorities, to operate Medicaid managed care programs that cover LTSS (MLTSS programs). For example, states can use 1115(a) demonstration waiver authority to implement MLTSS programs or can combine 1915(c) waiver authorities with 1915(a), 1915(b), or 1932(a) authorities. For examples of states that have used these combinations, see **Appendix C**. For more information on authorities that states can use to cover home and community-based services through Medicaid, see https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/index.html.

Key considerations for identifying appropriate Medicaid managed care authorities when using Pathway 1: Aligning D-SNPs with Medicaid managed care plans

This section provides three considerations to help states discern the most appropriate Medicaid managed care authority to use when aligning D-SNPs with new or existing Medicaid managed care plans. States that already have managed care programs that enroll dually eligible individuals can also use these considerations to examine the authorities currently in use and whether they need to change or amend those authorities to accommodate integrated care implementation. As noted previously, selecting a managed care authority can be a complex process dependent on several state-specific factors. The following considerations can provide high-level support in the early stages of states' decision-making processes, which should be conducted in partnership with CMS. States might also wish to engage with and invite feedback from other key partners, such as health plans, providers, beneficiaries, and beneficiary advocacy organizations.

Consideration 1: Does the state wish to enroll dually eligible individuals into the Medicaid managed care program on a voluntary or mandatory basis?

Some authorities do not allow for mandatory enrollment of dually eligible individuals. Medicaid managed care authorities that allow states to mandate enrollment of dually eligible individuals—the 1915(b) and 1115(a) waiver authorities—tend to have stricter requirements for cost-effectiveness and lengthier application processes than the authorities that allow only for voluntary managed care enrollment of dually eligible populations—the 1915(a) waivers and 1932(a) state plan amendments.

Consideration 2: Does the state want to limit the number of Medicaid managed care plans or contracted entities through selective contracting, or does the state intend to contract with all willing and qualified plans and entities?

Selective contracting allows states to limit the Medicaid managed care contracts they award based on the state's desired number of plans and plan characteristics. Almost all states use competitive procurements to selectively contract with comprehensive MCOs, and in most states, MCOs compete on program elements and demonstrated results.[3] States can also use Medicaid procurement criteria to require contracted Medicaid managed care plans to offer affiliated D-SNPs in the same service area, and then contract only with D-SNPs that have parent companies with state Medicaid managed care contracts.[4]

Under Section 1915(a) waiver authority, states may not use selective contracting to limit the number of qualified plans or entities involved in the program. Selective contracting is allowed under 1932(a) state plan amendments, 1915(b) waivers, and 1115(a) waivers. However, if a state uses 1932(a) state plan authority to

implement a managed care program, at least two plans or contracted entities must be offered in non-rural areas.

Consideration 3: Will the state use the managed care program to enroll populations or cover benefits that are not otherwise covered under the Medicaid state plan?

A state may need to use an 1115(a) or 1915(b) waiver authority if it wants to launch or modify a Medicaid managed care program that will cover certain populations not otherwise covered under the Medicaid state plan, or if it wants to expand benefit packages beyond standard Medicare and Medicaid benefits. Under 1115(a) waiver authority, states may test experimental projects, enroll additional groups, and offer services not otherwise covered. Although it is unlikely that a state would undergo the extensive 1115(a) application process solely to launch a new integrated care program for dually eligible individuals, states might decide to add dually eligible individuals to a managed care program that operates within an existing 1115(a) demonstration. Under 1915(b) waiver authority, states may mandate that dually eligible individuals (or other populations) enroll in managed care, selectively contract with providers or health plans, use a central enrollment broker, and use cost savings to provide additional health-related services to beneficiaries.[5] States may choose between these two authorities based on requirements for innovation and budget neutrality, among other factors.

Medicaid Managed care authority options for states using Pathway 2: Directly contracting with D-SNPs to cover Medicaid benefits for D-SNP enrollees

Contracting with D-SNPs to cover Medicaid benefits for their enrollees can serve as an alternative to enrolling dually eligible individuals in a separate Medicaid managed care program. When a D-SNP receives a capitated payment from a state to cover Medicaid benefits, the D-SNP serves as a Medicaid managed care plan. For that reason, the D-SNP is subject to all the federal regulations under 42 CFR 438 and the state must obtain CMS approval of: (1) a Medicaid managed care authority for the direct capitation arrangement with the D-SNPs; (2) the capitated rates to be used with the D-SNPs; and (3) the state's contracts with the D-SNPs. States using either pathway will also need to use rate-setting, contract management, and oversight resources to manage the program, just as they would with a traditional Medicaid managed care program. States might also need to obtain approval from the state legislature to cover Medicaid benefits for dually eligible individuals through a managed care program, even if that coverage will be provided via D-SNPs. In some states, contracting directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees might serve as an interim step to developing a broader managed care program that will enroll dually eligible individuals. In others, it might be viewed as a more palatable option for achieving integrated care than launching a broader Medicaid managed care program, as the affected population would be only a subset of dually eligible individuals who voluntarily choose to receive their benefits through the integrated D-SNP.

Because D-SNP enrollment is always voluntary, the two authorities states are most likely to use when contracting directly with D-SNPs for coverage of Medicaid benefits are (1) 1915(a) waiver authority, if the state *does not* want to limit the D-SNPs with which it contracts, and (2) 1932(a) state plan amendment authority, if the state *does* want to selectively contract only with certain D-SNPs. Although theoretically, a state may use 1915(b) waiver or 1115(a) demonstration waiver authorities for this purpose, the application processes for these authorities are significantly more complex than the processes used for 1915(a) and 1932(a) authorities.

Conclusion

This tip sheet summarizes federal Medicaid managed care authorities and key considerations for states as they design models to integrate Medicare and Medicaid benefits for dually eligible populations. The specific federal Medicaid managed care authorities that states choose to pursue when integrating care for dually eligible individuals can depend on a variety of factors, including the state's existing Medicaid managed care and D-SNP landscapes, whether the state currently enrolls dually eligible individuals into a Medicaid managed care program and whether that enrollment is voluntary, whether the state uses selective contracting, program timelines, and budget requirements. States should consider the flexibilities and limitations of each authority and examine how they align with the state's policy landscape, goals, and existing Medicaid waiver authorities or strategies. In addition to reviewing the considerations within this tip sheet, states should also partner with CMS to determine which authorities are the most appropriate for their needs.

ENDNOTES

[1] CMS. "Enrollment Report." https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html

[2] Regardless of which integrated care pathway or managed care authorities a state uses, states are always responsible for oversight of managed care plans' delivery of Medicaid benefits and compliance with federal and state Medicaid managed care requirements, as well as any state-specific requirements incorporated into a state's contract with a D-SNP. CMS is responsible for oversight of D-SNP delivery of Medicare benefits and compliance with federal D-SNP requirements.

[3] Forbes, M., and S. Dunbar. "Understanding Medicaid Managed Care Procurement Practices Across States." Presentation to Medicaid and CHIP Payment and Access Commission, April 8, 2022. https://www.macpac.gov/wp-content/uploads/2022/04/Understanding-Medicaid-Managed-Care-Procurement.pdf.

[4] Integrated Care Resource Center. "Selectively Contracting with Dual-Eligible Special Needs Plans (D-SNPs) to Promote Alignment with Medicaid Managed Care Plans." February 23, 2023. https://www.integratedcareresourcecenter.com/webinar/selectively-contracting-medicare-advantage-dual-eligible-special-needs-plans-d-snps-promote.

[5] CMS. "Managed Care Authorities." https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html. Accessed April 18, 2023.

Appendix A. Summary of Federal Medicaid Managed Care Authorities

Table A.1. Brief descriptions of the four federal Medicaid managed care authorities and the flexibilities and limitations of each

Authority	Description	Approval duration	Key flexibilities	Key limitations
Section 1932(a) state plan amendment	State plan authority that allows for mandatory and voluntary enrollment in managed care programs on a statewide basis or in limited geographic areas; enrollment of dually eligible individuals must be voluntary	Indefinite	• Selective contracting allowed • No cost-effectiveness or budget-neutrality requirements • Comparability of services, freedom of choice, and statewideness are not required	• No mandatory enrollment of dually eligible individuals
Section 1915(a) waiver	Waiver authority that allows for voluntary enrollment in managed care programs that operate on a statewide basis or in limited geographic areas	Approval length mirrors the length of the state's voluntary managed care organization contract	• Simplified application process • No cost-effectiveness or budget-neutrality requirements • Comparability of services, freedom of choice, and statewideness are not required	• No mandatory enrollment of dually eligible individuals • No selective contracting allowed
Section 1915(b) waiver	Waiver authority that allows for mandatory enrollment in managed care on a statewide basis or in limited geographic areas	Two years (five years if serving dually eligible individuals)	• Allows for mandatory enrollment of all state plan populations (including dually eligible individuals) • Selective contracting allowed • May provide additional, health-related services not covered under the state plan using 1915(b)(3) authority if specific conditions are met • Comparability of services, freedom of choice, and statewideness are not required	• Must be determined to be cost-effective and efficient • Requirements for the 1915(b) waiver are more administratively burdensome than 1915(a) or 1932(a) requirements
Section 1115(a) demonstration	Research and demonstration waivers that allow states to test experimental projects, including by waiving traditional Medicaid requirements or using innovative payment methods to administer managed care	Initially approved for five years	• Allows for mandatory enrollment of all state plan populations (including dually eligible individuals), as well as individuals not otherwise eligible for Medicaid • Selective contracting allowed • States can use managed care savings to offset the cost of the demonstration • Comparability of services, freedom of choice, and statewideness are not required	• Must demonstrate budget neutrality • Requirements for the 1115(a) waiver are more administratively burdensome than 1915(a) or 1932(a) requirements

Source: https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html

Appendix B. Three State Approaches to Integrating Medicare and Medicaid Benefits

Pathway 1: Aligning D-SNPs with affiliated Medicaid managed care plans owned by the same parent company as the D-SNP

- When **Virginia** concluded its Financial Alignment Initiative at the end of 2017, the state was simultaneously developing a statewide MLTSS program. In planning for these system changes, the state chose to selectively contract only with D-SNPs offered by the same parent companies as the state's new Commonwealth Coordinated Care Plus (CCC+) MLTSS plans. By requiring alignment of D-SNPs with affiliated MLTSS plans, the state ensured access to an integrated Medicare and Medicaid benefit package for its dually eligible population. Virginia's alignment policies allow D-SNP enrollees to enroll in any CCC+ plan of their choice, resulting in some D-SNP enrollees having "aligned" enrollment and others having "unaligned" enrollment. Although enrollment is not exclusively aligned for all of Virginia's D-SNP contractors currently, some Virginia D-SNPs operate with exclusively aligned enrollment by using separate plan benefit packages for aligned and unaligned enrollees. The state intends to require all contracted D-SNPs and affiliated MLTSS plans to operate with exclusively aligned enrollment in the future.[1]
- **Indiana** recently announced contract awardees for an MLTSS program the state is launching in 2024 that aims to promote use of HCBS, improve support for caregivers, and improve coordination of Medicare and Medicaid benefits for dually eligible individuals.[2,3] As part of this new program, Indiana intends to selectively contract with D-SNPs in 2025 that have affiliated Medicaid MLTSS plans and require those D-SNPs to operate with exclusively aligned enrollment.[4]

Pathway 2: Contracting directly with D-SNPs and paying them a per member per month rate to cover Medicaid benefits for D-SNP enrollees

- When the **District of Columbia's** Department of Health Care Finance (DHCF) first explored options for offering integrated Medicare and Medicaid benefits, people dually eligible for Medicare and Medicaid were not generally enrolled in any of the District's existing Medicaid managed care programs. Medicaid officials within DHCF recognized, however, that a substantial proportion of its dually eligible LTSS population were already voluntarily enrolled with its contracted D-SNPs. This led DHCF to seek options to offer a more coordinated experience for this subset of dually eligible individuals, as enrolling all dually eligible individuals into a broader Medicaid managed care program would have been a significantly larger undertaking for DHCF, health plans, and providers. After considering available pathways, the District chose to contract directly with D-SNPs to cover Medicaid benefits and cost-sharing for dually eligible individuals already enrolled in the District's D-SNPs. This direct contracting approach could be advanced on a smaller scale, while still achieving fully integrated benefits for D-SNP enrollees. In addition, this approach did not directly impact other dually eligible individuals who chose to receive their Medicare benefits through fee-for-service Medicare or non-D-SNP Medicare Advantage plans.

[1] For definitions of aligned enrollment, unaligned enrollment, selective contracting, and exclusively aligned enrollment, see ICRC's February 23, 2023, webinar on selectively contracting with D-SNPs to promote alignment with Medicaid managed care plans, at https://www.integratedcareresourcecenter.com/webinar/selectively-contracting-medicare-advantage-dual-eligible-special-needs-plans-d-snps-promote.

[2] Information about Indiana's MLTSS program is available at https://www.in.gov/fssa/indiana-pathways-for-aging/managed-long-term-services-and-supports/.

[3] Information about Indiana's March 1, 2023, announcement of contract awardees for its new MLTSS program is available at https://www.in.gov/idoa/procurement/award-recommendations/.

[4] Details about Indiana's plans to selectively contract with D-SNPs and require D-SNPs to operate with exclusively aligned enrollment in the future are available in the state's D-SNP contract at https://www.in.gov/medicaid/partners/medicaid-partners/dual-eligible-special-needs-plans/.

Appendix C. Medicaid Managed Care Authorities Used in State Medicaid Managed Care Programs Serving Dually Eligible Individuals in 2020

Table C.1. State Medicaid managed care programs serving dually eligible individuals, 2020[a]

State	Levels of D-SNP integration (2023)	Medicaid managed care programs that enroll dually eligible individuals (2020)[b,c]	Medicaid managed care authorities used (2020)	Enrollment of full-benefit dually eligible individuals in the Medicaid managed care program
Arizona	FIDE SNP and HIDE SNP	Arizona Health Care Cost Containment System (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
Arkansas	CO D-SNP	Provider-Led Arkansas Shared Savings Entity Program (Comprehensive MCO + MLTSS)	1915(b), 1915(b)/1915(c), 1915(b)/1915(i)	Varies
California	FIDE SNP and CO D-SNP, AIP	County Organized Health Systems Model (Comprehensive MCO + MLTSS)[d]	1115(a) (changed to 1915(b) as of 2022)	Mandatory
		Regional Model (Comprehensive MCO)[d]	1115(a) (changed to 1915(b) as of 2022)	Voluntary
		Geographic Managed Care Model (Comprehensive MCO + MLTSS)[d]	1115(a) (changed to 1915(b) as of 2022)	Mandatory
		Senior Care Action Network (Comprehensive MCO + MLTSS)	1915(a)	Voluntary
		Two-Plan Model (Comprehensive MCO + MLTSS)[d]	1115(a) (changed to 1915(b) as of 2022)	Varies
		Positive Healthcare/Los Angeles (Comprehensive MCO)[d]	1915(a)	Voluntary
Colorado	CO D-SNP	Denver Health Medicaid Choice (Comprehensive MCO)	1915(b)	Mandatory
		Accountable Care Collaborative: Rocky Mountain Health Plans Prime (Comprehensive MCO)	1915(b)	Mandatory
Delaware	CO D-SNP	Diamond State Health Plan & Diamond State Health Plan Plus (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
Florida	FIDE SNP, HIDE SNP, and CO D-SNP, AIP	Managed Medical Assistance Program (Comprehensive MCO)	1115(a)	Mandatory
		Long-Term Care Program (MLTSS only (PIHP and/or PAHP))	1915(b)/1915(c)	Mandatory
Hawaii	HIDE SNP	MedQUEST (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
Idaho	FIDE SNP and CO D-SNP, AIP	Idaho Medicaid Plus (Comprehensive MCO + MLTSS)	1915(b)/1915(c)	Mandatory

State	Levels of D-SNP integration (2023)	Medicaid managed care programs that enroll dually eligible individuals (2020)[b,c]	Medicaid managed care authorities used (2020)	Enrollment of full-benefit dually eligible individuals in the Medicaid managed care program
		Idaho Behavioral Health Plan (BHO only [PIHP and/or PAHP])	1915(b)/1915(i)	Voluntary
		Medicare/Medicaid Coordination Plan (Comprehensive MCO + MLTSS)	1915(a)/1915(c)	Voluntary
Illinois	*No D-SNPs*	HealthChoice Illinois MLTSS (MLTSS only [PIHP and/or PAHP])	1915(b)/1915(c)	Mandatory
Iowa	CO D-SNP	IA Healthlink (Comprehensive MCO + MLTSS)	1915(b)/1915(c), 1915(b)/1915(i)	Mandatory
Kansas	HIDE SNP	KanCare (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
Kentucky	HIDE SNP and CO D-SNP	Kentucky Managed Care (Comprehensive MCO)	1915(b)	Mandatory
Louisiana	CO D-SNP	Healthy Louisiana (BHO only [PIHP and/or PAHP])	1115(a), 1915(b), 1932(a)	Mandatory
Massachusetts	FIDE SNP, AIP	Senior Care Options (Comprehensive MCO + MLTSS)	1915(a)/1915(c)	Voluntary
		MassHealth BH/SUD PIHP (BHO only [PIHP and/or PAHP])	1115(a)	Mandatory
Michigan	CO D-SNP	Comprehensive Health Care Program (Comprehensive MCO)	1915(b)	Voluntary
		MI Choice (MLTSS only [PIHP and/or PAHP])	1915(b)/1915(c)	Voluntary
		Specialty Prepaid Inpatient Health Plans (BHO only [PIHP and/or PAHP])	1915(b)/19159c)	Voluntary
Minnesota	FIDE SNP and HIDE SNP, AIP	Minnesota Senior Care Plus (Comprehensive MCO + MLTSS)	1915(b)/1915(c)	Mandatory
		Minnesota Senior Health Option (Comprehensive MCO + MLTSS)	1915(a)/1915(c)	Voluntary
		Special Needs Basic Care (Comprehensive MCO + MLTSS)	1915(a)	Voluntary
Nebraska	HIDE SNP and CO D-SNP	Heritage Health (Comprehensive MCO)	1915(b)	Mandatory
New Hampshire	*No D-SNPs*	New Hampshire Medicaid Care Management (Comprehensive MCO)	1915(b), 1932(a)	Mandatory
New Jersey	FIDE SNP, AIP	NJFamilyCare (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
		FIDE SNP (Comprehensive MCO + MLTSS)	1115(a)	Voluntary
New Mexico	HIDE SNP	Centennial Care (Comprehensive MCO + MLTSS)	1115(a)	Mandatory

State	Levels of D-SNP integration (2023)	Medicaid managed care programs that enroll dually eligible individuals (2020)[b,c]	Medicaid managed care authorities used (2020)	Enrollment of full-benefit dually eligible individuals in the Medicaid managed care program
New York	FIDE SNP, HIDE SNP, and CO D-SNP, AIP	Medicaid Advantage Plus (Comprehensive MCO + MLTSS)	1115(a)	Voluntary
		Managed Long Term Care (MLTSS only (PIHP and/or PAHP)	1115(a)	Mandatory
North Carolina	CO D-SNP	1915(b)/(c) Medicaid Waiver for MH/DD/SA Services (BHO only [PIHP and/or PAHP])	1915(b)/1915(c) (state will move to comprehensive managed care using 1115(a) authority in 2023)	Mandatory
Ohio	CO D-SNP	MyCare Ohio Opt-Out Program (Comprehensive MCO + MLTSS)	1915(b)/1915(c)	Mandatory
Oregon	HIDE SNP and CO D-SNP	Oregon Health Plan (Comprehensive MCO)	1115(a)	Voluntary
Pennsylvania	FIDE SNP, HIDE SNP, and CO D-SNP	Physical HealthChoices (Comprehensive MCO)[e]	1915(b)	Mandatory
		Community HealthChoices (Comprehensive MCO + MLTSS)	1915(b)/1915(c)	Mandatory
		Behavioral HealthChoices (BHO only [PIHP and/or PAHP])	1115(a), 1915(b)	Mandatory
Puerto Rico	HIDE SNP, AIP	Government Health Plan (Comprehensive MCO)	1932(a)	Mandatory
Tennessee	FIDE SNP, HIDE SNP, and CO D-SNP, AIP	TennCare II (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
Texas	HIDE SNP and CO D-SNP	STAR+PLUS (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
Utah	CO D-SNP	UNI HOME (Comprehensive MCO)	1915(a)	Voluntary
		Choice of Health Care Delivery (Comprehensive MCO)	1915(b)	Varies
		Utah Prepaid Mental Health (BHO only [PIHP and/or PAHP])	1915(b)	Mandatory
Vermont	*No D-SNPs*	Global Commitment to Health Demonstration (Comprehensive MCO + MLTSS)	1115(a)	Mandatory
Virginia	FIDE SNP, HIDE SNP, and CO D-SNP, AIP	Commonwealth Coordinated Care Plus (Comprehensive MCO + MLTSS)	1915(b)/1915(c)	Mandatory
Washington	HIDE SNP and CO D-SNP	Behavioral Health Services Only (BHO only [PIHP and/or PAHP])	1915(b)	Mandatory

State	Levels of D-SNP integration (2023)	Medicaid managed care programs that enroll dually eligible individuals (2020)[b,c]	Medicaid managed care authorities used (2020)	Enrollment of full-benefit dually eligible individuals in the Medicaid managed care program
Wisconsin[f]	FIDE SNP and HIDE SNP, AIP	SSI Managed Care (Comprehensive MCO)	1932(a)	Voluntary
		BadgerCare Plus (Comprehensive MCO)	1932(a)	Voluntary
		Family Care Partnership (Comprehensive MCO + MLTSS)	1932(a)/1915(c)	Voluntary
		Family Care (MLTSS only [PIHP and/or PAHP])	1915(b)/1915(c)	Voluntary

Sources:

- State Medicaid managed care program information is from the 2020 Medicaid Managed Care Enrollment Report, available at https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html.
- Information on level of D-SNP integration is from the CMS SNP Comprehensive Report, April 2023, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.

Notes:

FIDE SNP = fully integrated dual eligible special needs plan, HIDE SNP = highly integrated dual eligible special needs plan, CO D-SNP = coordination-only dual eligible special needs plan, AIP = applicable integrated plan.

BHO = Behavioral Health Organization, PIHP = prepaid inpatient health plan, PAHP = prepaid ambulatory health plan

[a] This table excludes stand-alone dental and transportation programs, as states would not be likely to align managed care plans in those programs with D-SNPs.

[b] The following states cover at least some LTSS under the Medicaid managed care programs represented in this table: Arizona, Arkansas, California, Delaware, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Tennessee, Texas, Vermont, Virginia, and Wisconsin.

[c] The District of Columbia uses 1915(a) authority to contract directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees, and Indiana is pursuing a combined 1915(b)/1915(c) waiver for its MLTSS program that will launch in 2024. This table does not include these programs, because the programs began after 2020.

[d] California is enrolling most dually eligible individuals into a statewide Medi-Cal managed care system in 2023 as part of its CalAim initiative. More information is available at https://www.dhcs.ca.gov/services/Pages/Statewide-Medi-Cal-Managed-Care-Enrollment-for-Dual-Eligible-Beneficiaries.aspx. As part of CalAim, the state is also shifting the managed care models used in some counties (https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.aspx).

[e] Pennsylvania's Physical Health HealthChoices program only enrolls dually eligible individuals under age 21.

[f] Wisconsin allows individuals who are already enrolled in BadgerCare Plus when they become dually eligible to remain enrolled in BadgerCare Plus. However, the state does not allow dually eligible individuals to enroll in BadgerCare Plus if they are already dually eligible when they wish to enroll.