NASDDDS
National Association of State Directors of Developmental Disabilities Services

I/DD Dual Eligibility Toolkit: State Policy Considerations

Dual Eligible Integration Opportunities to Improve Supports for People with Intellectual and Developmental Disabilities

National Dual Eligibles Footprint

In Fiscal Year 2024, approximately 12.8 million individuals in the United States were dually eligible for both Medicare and Medicaid services. These “dual eligibles” are individuals—often older adults or people with disabilities—who qualify for Medicare based on age or disability and for Medicaid due to income and resource limits. Of this population, 8.9 million are considered "full duals," meaning they qualify for the full range of benefits under both programs. The remaining individuals are "partial duals," who receive limited Medicaid support, typically for premiums or cost-sharing. Among the full duals are individuals with intellectual and developmental disabilities (I/DD), who frequently require a high level of coordination between acute medical care and long-term support services to ensure their complex needs are met.

To address these needs, states are exploring a variety of approaches. One involves work in partnership with the Centers for Medicare & Medicaid Services (CMS) to contract with private health plans to implement Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). D-SNPs are a specific form of Medicare Advantage plan designed to serve dually eligible beneficiaries by aligning Medicare and Medicaid benefits. Each D-SNP must operate under a State Medicaid Agency Contract (SMAC) with the state's Medicaid agency, which outlines key requirements for coordination of care, data exchange, and member support. This contract is renewed yearly at the state’s discretion.

D-SNPs fall into three categories, highlighted in Figure 1. [1] Each represents a different level of Medicare-Medicaid integration:

- Coordination-Only (CO) D-SNPs are the most common used by states and focus on basic coordination of Medicare and Medicaid benefits. For example, Texas employs this model, requiring plans to share data and support care transitions, while retaining separate Medicaid program operations.
- Highly Integrated (HIDE) D-SNPs go a step further by assuming Medicaid financial risk for services like behavioral health or long-term services and supports (LTSS). Arizona is a leader in this model, offering plans that align with Medicaid managed care organizations to deliver more unified support to members.
- Fully Integrated (FIDE) D-SNPs represent the most comprehensive approach. These plans integrate Medicare, Medicaid, behavioral health, and LTSS under a single entity and require exclusively aligned enrollment (EAE), meaning enrollees receive both Medicare and Medicaid benefits from the same plan. Minnesota serves as a national example through its Minnesota Senior Health Options (MSHO) program, which has long used FIDE D-SNPs to deliver person-centered care through fully integrated systems.

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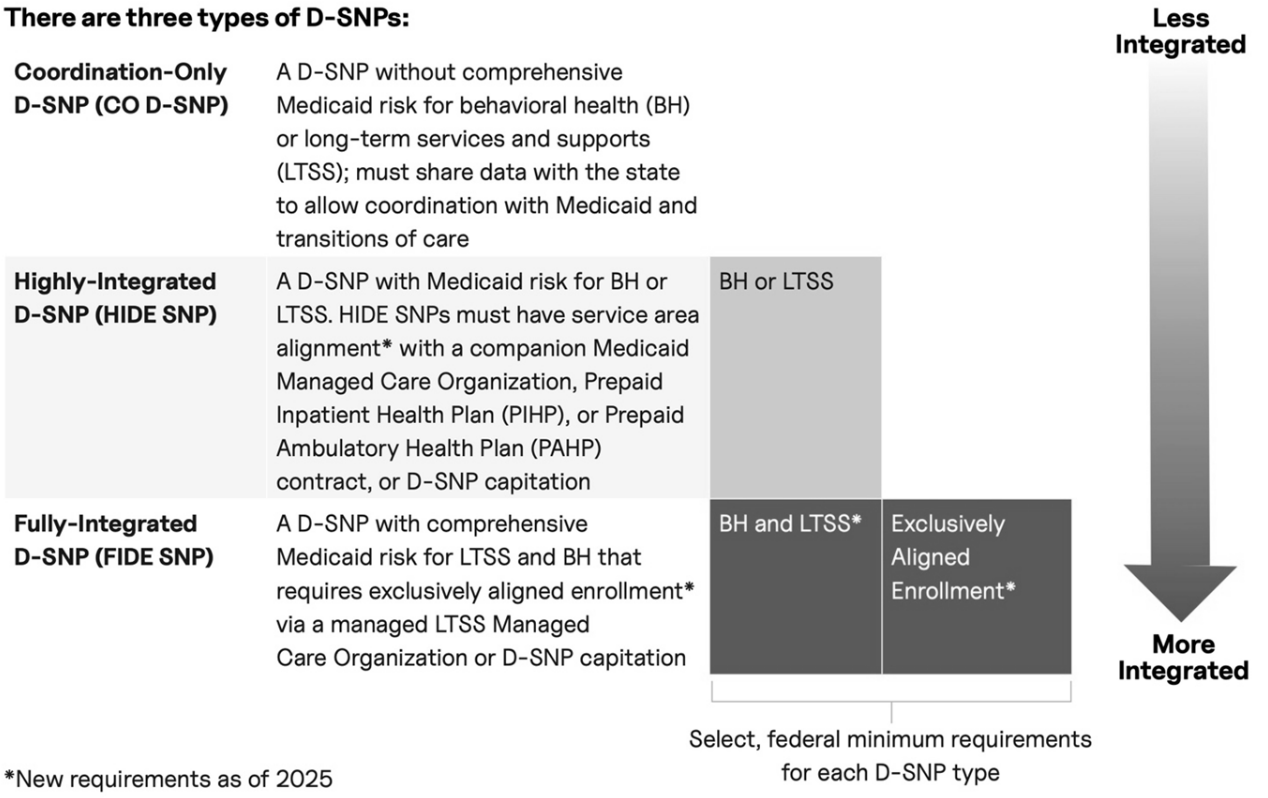
[1] ATI Advisory. (2024, August). *Different types of dual eligible special needs plans (D-SNPs)*. https://atiadvisory.com/resources/wp-content/uploads/2024/08/ATI_CapitatedDNSPs-tipsheet.pdf

Figure 1. Three Types of Dual Eligible Special Needs Plans[2]



There are three types of D-SNPs:

Coordination-Only D-SNP (CO D-SNP)	A D-SNP without comprehensive Medicaid risk for behavioral health (BH) or long-term services and supports (LTSS); must share data with the state to allow coordination with Medicaid and transitions of care		
Highly-Integrated D-SNP (HIDE SNP)	A D-SNP with Medicaid risk for BH or LTSS. HIDE SNPs must have service area alignment* with a companion Medicaid Managed Care Organization, Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) contract, or D-SNP capitation	BH or LTSS	
Fully-Integrated D-SNP (FIDE SNP)	A D-SNP with comprehensive Medicaid risk for LTSS and BH that requires exclusively aligned enrollment* via a managed LTSS Managed Care Organization or D-SNP capitation	BH and LTSS*	Exclusively Aligned Enrollment*

Select, federal minimum requirements for each D-SNP type

*New requirements as of 2025

In addition to SMAC strategies, many states are strengthening their community-based infrastructure to support people who are dually eligible—especially those with I/DD—through trusted information and referral (I&R) networks, including the state's I/DD service delivery system and websites, Aging and Disability Resource Centers (ADRCs), State Health Insurance Assistance Programs (SHIPs), and state/local ombudsman programs. These networks play a critical role in helping individuals and caregivers understand coverage options, navigate complex benefit systems, and select plans that match their needs.

States also are advancing person-centered engagement approaches that reflect the unique needs of their populations. This includes investing in local partnerships with groups and community providers, case managers, tribal organizations, disability advocacy groups, independent living centers, and faith-based organizations to ensure people can access support through channels they trust. Some states are using shared online resources, decision-making tools and peer navigator programs to help explore Medicare plan options in a way that is both empowering and informed.

As CMS continues to refine federal standards for D-SNPs—particularly around integrated service areas, unified appeals processes, and mandatory behavioral health benefits—states are evolving their strategies to meet these requirements while centering the voices and preferences of dual-eligible populations. This includes other state agencies that serve Medicaid populations becoming more engaged in these discussions and in the decisions being made about care coordination and integration for dually eligible individuals.

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[2] ATI Advisory. (2024, August). *Different types of dual eligible special needs plans (D-SNPs).* https://atiadvisory.com/resources/wp-content/uploads/2024/08/ATI_CapitatedDNSPs-tipsheet.pdf

Key State Dual Coordination/Integration Areas: Phasing Opportunities

This summary outlines some key areas state I/DD authorities may consider in working with their state Medicaid agency (SMA) counterparts to advance education, increase awareness, and improve care coordination for dually eligible people with I/DD. Some areas also present opportunities beyond the use of a state's SMAC to influence system changes and are reflected over a short-term period, (within one year), an intermediate period (within two years) and/or a long-term timeframe (beyond two years). These strategies, successfully implemented in other states, can serve as future goals to improve alignment of services and supports for individuals with I/DD who are dually eligible. Additionally, these approaches may be adapted for the broader dually eligible populations across the state.

1) Covered Populations in SMACs

States can include or limit different types of dually eligible members in SMACs as well as establish processes to verify dual eligibility status for individuals across Medicare and Medicaid systems. They can specify the dual eligible types they wish to include (i.e., a "full benefit" dual eligible), and set data sharing and/or reporting requirements for specific dual eligible types in the SMAC agreement.

	Action	Benefits	Considerations
Short Term	Start with specific populations of dual eligible members if the state does not wish to include all dually eligible individuals. For example, a state may only be interested in covering a specific population for the purpose of reporting for a state requirement, such as a population in a Settlement Agreement or other state priority, such as members with I/DD who use HCBS services. States can also require D-SNPS to report on all dually eligible members with I/DD as a separate group.	SMAs are already signing off on SMACs yearly to allow D-SNPs to operate in their state and have the control to amend the SMAC every year. Expanding the population in the SMAC allows the state to fill "blind spots" regarding people being served by the D-SNPs in terms of who they are supporting, how they are coordinating their care, and what types of services they are receiving. SMAs and State Operating Agencies (SOAs) can use this data to benchmark standards of care, as well as monitor, trend, and use this information to influence improvements in care coordination or integrated service delivery. States can start with reporting for a smaller population to gain experience, expanding to other populations in phases.	If the SMAC is targeted to a specific population, this limits the amount of information the state is receiving about Medicaid members in Medicare D-SNPs. As a reminder – D-SNPs cover all dually eligible members, including those with I/DD. The data states receive from D-SNPs can include all Medicaid-enrolled members with I/DD. This data will give states a picture of how their dually eligible members with I/DD use Medicare services. States could also start with a smaller subset of this population, such as those members with I/DD who use HCBS services. Staff are needed to receive and analyze data. States tend to start with assigning this responsibility to existing staff and add new staff as necessary. Staff will require Medicare education/training if they are not already experienced with the program, especially as it pertains to dual eligibility. Additional resources that may be needed for expanded operations including storage of the data if it doesn't exist (i.e., a data warehouse).
Intermediate	Expand/include other populations as system capacity and interest grows.		

2) Medicare Data, Reporting & Monitoring

States receive point-in-time Medicare eligibility data through the State Medicare Modernization Act (MMA) file that identifies if an individual is a Medicare beneficiary. States also sometimes require D-SNPs to submit additional data to identify and accurately track dual eligible beneficiaries within the state Medicaid system. States can dictate how often they wish to receive data from the D-SNPs and in what format. Examples of data states start with to monitor their systems may include, but are not limited to:

- MMA file data (member eligibility information)
- Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®), or member scores
- Member enrollment and disenrollment data
- Appeals and grievance data
- Transitions of care data, such as hospital and skilled nursing facility (SNF) admissions for target populations

	Action	Benefits	Considerations
Short Term	The SOA receives Medicare point-in-time eligibility data to identify members with I/DD.	This information will help tell the SMA and SOA the number of members with I/DD who are dually eligible in the system, which plan(s) serve them, and based on their dual eligibility classification, what types of Medicare services they can receive.	The SMA may need to expand beyond Medicaid compliance to include other subject matter experts and identify 'who owns what' with Medicaid and if there is a process for review, if any. Once this is established, the SOA may wish to receive and analyze the data themselves or partner with the Medicaid agency to analyze the data until the SOA is more comfortable with the data/process. State staff will need staff capacity and likely training to understand and use the data.
	The SOA receives admissions notification data from the D-SNP regarding members with I/DD and who are transitioned or diverted from hospitals or other institutional settings.	This will help the SOA to better understand how many members are experiencing transitions or diversions in their system, and why. Once a baseline is established, periodic monitoring of these data can inform the SOA what target training/intervention requirements may be needed in the SMAC to influence support provided to members with I/DD.	

	Action	Benefits	Considerations
Intermediate	The SOA receives enrollment and disenrollment, grievance and complaint data and information pertaining to members with I/DD.	The SOA will better understand member health care utilization patterns. Data will be helpful when planning to advance member benefit integration and alignment between both programs.	If the SMA already receives these data, the SOA could consider requesting to participate in the data review process together. If staff resources are an issue, consider working with the SMA directly to review the data on a regular basis or identify a regular report the SOA could receive that includes the data. The SOA could also consider requesting the SMAC be amended to include separate reporting for members with I/DD.
	The state requires data and reports that align with existing state/federal reporting measures and member surveys. They include, but are not limited to HEDIS data/reports, CAHPS® surveys, CMS Core Adult, Child Quality measures and state specific outcome measures (such as the National Core Indicators® survey).	Reporting requirements can support state priorities for specific populations or interventions; many measures are already established and are being collected by the state. Beginning with these measures can help simplify the process for deciding where to begin. In addition, states require D-SNPs to report on specific measures, such as reported incidences of falls or abuse and neglect, to align with their quality reporting for HCBS	Some SMAs may reserve the right to receive the data but haven't started the process to receive it yet. Others SMAs may be receiving this type of data but due to a variety of reasons may be analyzing only some data. The SOA could commit to meet with SMA to discuss the types of data they currently require, exploring opportunities to receive data and determine how to monitor going forward. Consider choosing requirements that will support existing state reporting processes. For example, reports on abuse and neglect help fulfill the HCBS quality assurance requirements.

	Action	Benefits	Considerations
Long-Term	The state requires D-SNPs to provide Medicare encounter (health claims) data.	States that use managed care for their Medicaid programs may already be requiring this data and, therefore, may not create a heavy lift for systems changes/capacity. Some states reserve the right to receive Medicare encounter data but have not yet required its submission to the state. States leverage this data to receive in-depth insights on Medicare health care utilization patterns of their Medicaid members. This data also helps to influence other state decisions about how they require D-SNPs to integrate Medicare and Medicaid services.	D-SNPs are used to this requirement from other states. This requirement isn't a significant expectation for D-SNPs if the state is ready to receive it and D-SNPs are given ample time to receive reporting requirements and modify systems to report, as appropriate. The heavier lift is on the state side – staff need an in-depth understanding of encounters, their processing, and their analysis. This may require additional staff as well as data storage capacity, depending on how the state warehouses and analyzes its data. SOAs that are not experienced with encounter data could collaborate with SMAs to analyze it, as appropriate.

3. Beneficiary Outreach and Education

States work closely with **State Health Insurance Program** (SHIP) counselors and **self-advocates and community members** in the state to provide education and expand awareness so they may determine how to best support members with I/DD. Activities may include regular meetings to discuss system issues, education and awareness training, and collaboration on member materials.

States leverage SMACs by setting outreach strategy requirements for D-SNPs to inform dual eligible beneficiaries about available integrated care options. They tend to require D-SNPs to submit marketing or communication materials, especially if any mention is made of the Medicaid program. States review materials to ensure member benefits, access, and member rights are clearly explained in a manner suitable to the state. States can also require MCOs to use state-defined templates for marketing or communication materials.

	Action	Benefits	Considerations
Short Term	The state requires in its SMAC a review of Medicaid broadcast mailings and the SOA becomes a part of the Medicaid document review process for the mailings.	Many states that have SMACs start with the review of broadcast mailings. Participation in the SMA's existing review process will provide the SOA with a better understanding of what materials are shared with members and how those materials can be used by case managers and other HCBS providers to educate members and their families. The SOA staff could review materials and provide meaningful feedback that would benefit members with I/DD and their families/caregivers. This includes reviewing materials for ease of reading (i.e., using plain language).	If the SMA already receives broadcast mailings and benefit comparison charts, the SOA team could explore being a part of the existing process with Medicaid for broadcast mailings. If this requirement is new to the state, the SOA could collaborate with the SMA to determine the best way to receive and review materials going forward. The SOA would need to understand how frequently this process occurs and how much staff time is required.
	The state strengthens its working relationship with the SHIP by establishing regular meeting/communication opportunities.	The SHIP and the SOA could identify areas to work together as it pertains to dually eligible members with I/DD and their families. This could include SHIP education on the unique needs of the I/DD population.	SHIP is a federally funded system that exists in each state. However, some areas may have volunteers instead of paid staff. Some SMAs already have established relationships with their SHIPs. Internal I/DD staff may need training on SHIP resources. The SHIP staff may have a strong understanding of dual eligibility but not understand the nuances of the Medicaid-funded I/DD system.

	Action	Benefits	Considerations
	The SOA requires the addition of question(s) to be used during the state's Medicaid service plan development and review process that target: • identifying those individuals who may become eligible for Medicare and connect them to Medicare resources if needed. • Supporting individuals with I/DD who are dually eligible to use and maximize their Medicare benefits.	The questions will help those supporting the care planning process to identify individuals who may need additional supports/resources about dual eligibility, and what it means for them and their health care needs. Individuals with I/DD and their families can be referred to Medicare resources.	Scenario examples with questions were created by NASDDDS for state use and may be found at the following link_____.
Intermediate	Any of the short-term options could be prioritized into an intermediate timeframe consideration to accommodate staffing/system capacity and timing needed to obtain necessary state authorities and funding, as appropriate.		

4. Care Coordination and Integration

Many states require care alignment and/or direct enhanced care coordination for dual enrollees, including direction regarding transitions of care. Examples of areas targeted by states include:

Managed care contracts. States negotiate requirements in contracts with Medicaid managed care organizations to ensure coordinated care for dual eligible enrollees. Some states require their Medicaid managed care plans to have a companion D-SNP and allow for default enrollment. Others take it a step further and only allow managed care plans operating as Medicaid plans to operate D-SNPs in the state (called exclusively aligned enrollment). These requirements typically occur in states where Medicaid managed care exists, and states are moving into more highly integrated or fully aligned Medicare/Medicaid programs. It can take several years to accomplish this level of integration, but it can be worth it as **D-SNPs may receive a higher monthly capitated payment for covering individuals with a chronic "condition" including individuals with I/DD**. This means D-SNPs receive additional funding to account for the higher acuity needs and costs of individuals with I/DD and can absorb additional state requirements as a part of doing business. As with every contract, these changes are negotiated every year between states and D-SNPs.

Care coordination/transition management. States implement strategies to manage care transitions between inpatient, outpatient, and long-term care settings for dually eligible individuals. There are a range of examples of care coordination strategies including requiring health risk assessments, expectations for the development of individualized care plans (ICPs), interdisciplinary care team (ICT) requirements, care coordinator/manager expectations, and requirements for transitions. Some states even require the MCOs to use certain providers, such a community-based organizations (CBOs), which are often area agencies on aging and community-mental health centers.

States generally leverage state procurement processes and the SMAC to require MCOs to align enrollees and to require specific care coordination/transition management changes. This, however, takes time and can be a multi-year process if a state-procurement is necessary and/or if legislative approval for contracts is required.

	Action	Benefits	Considerations
Short Term	The state requires D-SNPs to provide data containing summaries or elements of the care plan, or the entire care plan for I/DD members.	The information will provide greater insight into the Medicare care planning process and allow it to align with the Medicaid care planning process. The state can direct what types of elements it wants to include in the care plan to align with or complement Medicaid requirements for individuals with I/DD.	SOAs are delegated operational responsibility for Medicaid programs, such as individuals with I/DD, and could collaborate with the Medicaid agency to identify business users, develop these requirements, including specific ones pertaining to members with I/DD. States would need to consider data capacity, staff capacity and understanding of care coordination to receive and analyze data, as well as ways to collaborate on this process.
	The state adds a requirement regarding who participates on the I/DD member's ICT to include a community partner, provider, or other support partner.	It ensures trusted I/DD system and community partners/advocates participate in the ICT process.	States can require this, but it can be challenging to oversee/monitor. This is where monitoring mechanisms, such as member advisory committee reports and surveys can support the state in ensuring this requirement is honored.

	Action	Benefits	Considerations
Intermediate	The state sets knowledge, skills, and abilities requirements for D-SNP care coordinators who work with I/DD members. For example, NY requires experience working with individuals who have an I/DD.	The state can ensure ICT staff have the knowledge, skills, and experience that meet the needs of members with I/DD (or other populations, as appropriate).	States have used existing case manager or support broker requirements to align with state Medicaid program processes and support workforce retention. This may be considered an intermediate or long-term consideration after the ICT requirement is put into place.

5. Stakeholder Engagement

States are very involved in stakeholder engagement to ensure robust participation in system delivery. Some areas states are targeting regarding dual enrollees include:

Provider Education: in which states require D-SNPs to train healthcare and other community providers on the unique needs of dually eligible individuals and how to navigate the integrated care system. Some states even require the type of training and frequency.

Member Engagement: States empower dually eligible members to actively participate in their care decisions and understand their coverage options. This is a growing trend among states to require member advisory committees to include specific groups of representatives with lived experience to ensure appropriate representation.

Community partners: States are working more to collaborate with member advocacy organizations to gather feedback and address concerns related to needs of people who are dually eligible.

	Action	Benefits	Considerations
Short Term	State SOAs meet consistently with self-advocates and community partners to discuss dual eligibility.	Ensures individuals with lived experience and other critical players are meaningfully participating. Strengthens a knowledge base and understanding of dual eligibility. Leverages relationships with community partners. The state regularly receives feedback and support in setting future goals.	Consistent feedback from self-advocates can be challenging due to scheduling and financial constraints for people to participate. State SOAs and SMAs can consider virtual options as well as financial compensation for participation that do not affect program eligibility. This process also may include other critical partners as needed, including the D-SNPs and other agencies/community partners.

	Action	Benefits	Considerations
Short Term	State SOAs and SMAs establish regular meetings to discuss dually eligible member priorities and how the agencies may be aligned.	Strengthens a knowledge base and understanding of dual eligibility between the agencies and how each system is working with members who are dually eligible, including those with I/DD. Presents opportunities to align priorities and share resources to meet established priorities.	Some state agencies establish regular meeting schedules to discuss dual eligibility as a distinct topic, or incorporate duals as a part of priority areas they already review.
	States set provider education requirements for D-SNPs, especially as it pertains to supporting members with I/DD. States also may require specific training for support coordinators, provided by the D-SNPs at their direction.	Ensures consistent training and education of D-SNP staff and providers on specific areas/populations with the frequency desired by the state.	Training requirements may involve proprietary licenses/fees. If so, this will have an additional cost to the D-SNPs that affect the timing of the requirement, perhaps moving to a longer-term goal.

	States require the D-SNPs to submit member advisory committee meeting summaries on a periodic basis established by the state.	Provides an understanding of the issues members are bringing to the D-SNPs. Helps to identify systemic care issues that need to be addressed. Ensures meetings are occurring and they are meaningful in nature.	States can reserve the right to require meeting summaries of the meetings as well as require submission of the summaries. They determine how frequently this information is provided (i.e., every six months or annually). Staff capacity is necessary to review/follow meeting summaries. States could consider mandating that state staff reserve the right to attend member advisory meetings, as appropriate.
Intermediate	States specify what types of member(s) should be included on the member advisory committees, including a member(s) with I/DD (and/or family members).	States require member advisory committees include specific populations to ensure they are sufficiently represented.	D-SNPs do have the same struggle as states with finding members who are willing and able to meaningfully participate. Meaningful participation is enhanced when D-SNPs offer stipends, cover member travel expenses and offer flexibility with the meeting (virtual and held on evenings/weekends).
	States require D-SNPs to participate in regular community partner meetings, including specifying which groups they need to meet with, including frequency.	States require these meetings to ensure continued engagement with key community partners.	Depending on state staff capacity, some states require meeting minute submissions as evidence the meetings are occurring, or reserve the right to have state staff participate in these meetings.

Conclusion

States have a unique and critical opportunity to strengthen coordination and integration for individuals who are dually eligible for Medicare and Medicaid—particularly for those with I/DD. By leveraging tools such as SMACs, community partnerships, data reporting, and stakeholder engagement, states can build a more inclusive and person-centered system of care. These strategies not only improve health outcomes and quality of life for beneficiaries, but also support more efficient program administration, better alignment of resources, and a stronger understanding of beneficiary needs.

As the federal landscape continues to evolve, states are encouraged to assess their current integration efforts and explore phased strategies that fit their system's capacity and goals. Whether through expanding covered populations in SMACs, enhancing care coordination protocols, or increasing outreach and education, states have the flexibility to customize their approach. The path toward full integration may look different across states, but the shared goal remains the same: ensuring dually eligible individuals receive seamless, high-quality, and equitable care that supports their independence and well-being.

Resource List

1. Centers for Medicare & Medicaid Services. (2023). *Medicare-Medicaid Coordination Office: Data analysis brief – Dually eligible beneficiaries* (FY 2024). Retrieved from https://www.cms.gov/files/document/fy2024-dually-eligible-beneficiaries-brief.pdf
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