What, Why, and How Fundamentals for a D-SNP

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Dual-eligible Special Needs Medicare Advantage plans (D-SNPs) have been a popular, growing trend in the Medicare Advantage (MA) marketplace over the past several years. D-SNPs are MA plans that are geared to meet the unique needs of beneficiaries that are dually eligible for both Medicare and Medicaid. Since 2018, the number of D-SNP plans has increased 99.8% and enrollment in D-SNP plans has grown at an average annual rate of 18.1%.[1] As of January 2023, CMS reported enrollment in Special Needs Plans of almost 5.5 million members or about 17.7% of Medicare Advantage enrollment.[2] This white paper provides the fundamentals for understanding what a D-SNP is, the different kinds of D-SNPs, and some considerations for developing D-SNP plans for inclusion in a Medicare Advantage Organization's (MAO) portfolio of plan options.

What is a D-SNP?

D-SNPs enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States may cover some Medicare costs, depending on the state and the individual's eligibility[3]. Eligibility for a D-SNP is defined at both the federal level (Medicare) and state level (Medicaid). Specifics of Medicaid coverage and eligibility vary by state.

Medicaid statuses are identified in the Monthly Membership Report (MMR) from Center for Medicare and Medicaid Services (CMS). The ten (10) Medicaid status codes are assigned to a member using eligibility requirements including income, resources (assets e.g. bank accounts, stocks, bonds, etc.) Medicaid Status Codes 02, 04, and 08 are generally defined as Full benefit dual meaning the beneficiary is entitled to Medicare Part A, meets income requirements, and is eligible for full Medicaid benefits. For the Full duals, Medicaid pays the Part A premium (if any), the Part B premium and may pay cost sharing related to Medicare eligible services. Partial duals have higher income or assets so are eligible for varying levels of support but less than the Full duals.

The following section lists the 10 Medicaid status codes and how they are defined by CMS.

[1] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/special-needs-plan-snp-data-items/snp-comprehensive-report-2018-01

https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/special/snp-comprehensive-report-2023-01

[2] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/contract-summary-2023-01

[3] https://www.cms.gov/medicare/health-plans/specialneedsplans/d-snps

Dual-eligible Categories

- Qualified Medicare Beneficiary without other Medicaid (QMB Only) – Medicaid Status 01 in MMR;
    - Income:<100% Federal Poverty Line (FPL)
    - Resources:<= 3 times Supplemental Security Income (SSI)
    - Medicaid may pay Part A (if any) and Part B premiums, and Medicare cost sharing
- QMB with Full Medicaid (QMB Plus) – Medicaid Status 02 in MMR;
    - Income:<=100% FPL
    - Resources: Determined by State
    - Full Medicaid Coverage
    - Medicaid may pay Part A (if any) and Part B premiums, and Medicare cost sharing
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only) – Medicaid Status 03 in MMR;
    - Income:>100% FPL but <120% FPL
    - Resources <= 3 times SSI
    - Medicaid pays for Part B premiums
- Specified Low-Income Medicare Beneficiary with Full Medicaid (SLMB Plus) – Medicaid Status 04 in MMR;
    - Income>100% FPL but <120% FPL
    - Resources: Determined by State
    - Medicaid pays for Part B premiums
    - Medicaid pays Medicare cost sharing
- Qualified Disabled and Working Individual (QDWI) – Medicaid Status 05 in MMR;
    - Income: <200% FPL
    - Resources: <=2 times SSI
    - Part A benefits lost due to return to work but is eligible to enroll and purchase Part A coverage
    - Medicaid pays for Part A premium (if any)
- Qualifying Individual (QI) – Medicaid Status 06 in MMR;
    - Income: >= 120% FPL but <135% FPL
    - Resources: <= 2 times SSI
    - Medicaid pays for Part B premiums

- Qualifying Individuals (2) (QI-2s) – Medicaid Status 07 in MMR;
    - Effective 1/1/1998 – 12/31/2002 only (included for a complete list of Medicaid Statuses)
- Full Medicaid (only) – Medicaid Status 08 in MMR
    - Determined by State
    - Medicaid may pay Part A (if any) and Part B premiums, and Medicare cost sharing
- Other – Medicaid Status 09 in MMR
    - Code used by a handful of states to indicate participation in a State-specific program that is not directly related to whether the beneficiary is or is not dually enrolled in Medicare and Medicaid - used with CMS approval only
- Other Full Dual – Medicaid Status 10 in MMR
    - Separate code to indicate beneficiary is eligible for S-CHIP (State Children's Health Insurance Program) and is entitled to Medicare (including Puerto Rico Medicaid and CHIP)

D-SNP Concept

The Medicare Modernization Act (MMA) of 2003 introduced the Special Needs Plans (SNP) which included Institutional SNPs (I-SNP), Chronic Condition SNP (C-SNP), and Dually Eligible SNP (D-SNP). The intention of the MMA bill was to improve continuity and coordination of care for targeted groups and, via D-SNPs, integrate the Medicare and Medicaid benefits through a single organization – the MAO.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and subsequent amendments by the Patient Protections and Affordable Care Act (ACA) of 2010 requires D-SNPs to contract with the Medicaid program in the state in which they operate. This contract is referred to as the State Medicaid Agency Contract or SMAC. The SMAC requirement gives each state the authority to implement regulations affecting Medicaid managed care and creating other requirements on D-SNPs. As a result, the benefit coverage and eligibility requirements for D-SNPs may vary state to state. The SMAC also clarifies information sharing between CMS, the MAO, and the State Medicaid Agency.

At a minimum, in addition to Medicare benefits, the D-SNP must meet the state requirements for coordination of Medicaid benefits. Additional actions states may employ include:

- Contract directly with the MAO through the D-SNP to cover Medicaid benefits

- Require coverage of supplemental benefit packages that complement Medicaid benefits
- Require use of specific or enhanced care coordination methods
- Implement reporting requirements for oversight purposes

Each state has the authority to implement regulations affecting Medicaid managed care and creating additional requirements for D-SNPs.

- Incorporate Medicaid quality improvements into the SMAC
- Automate Medicaid crossover claim payment processes
- Establish default enrollment rules for dually eligible members

Managed Long Term Services and Supports (MLTSS)

MLTSS refers to the delivery of long-term services and supports through capitated Medicaid managed care programs. MLTSS programs are designed to service individuals with both age and disability-related long-term care needs, with the goal of providing high-quality, person-centered, and cost-effective care to eligible beneficiaries in their setting of choice. While a MLTSS program may be a stand-alone program; a number of states are integrating MLTSS between Medicaid and Medicare through a D-SNP, which results in the health plans having incentives for coordinating both Medicare and Medicaid service delivery.

Examples of benefits covered by MLTSS include:

- Adult day service
- Home and vehicle modifications
- Homemaker services including meals, nonmedical support, and assistance with activities of daily living
- Nursing care (home health aide, intermittent nursing, and skilled nursing)
- Behavioral services and alcohol/substance abuse rehabilitation services through residential programs
- Home delivered meals

D-SNP Types

COORDINATION ONLY DUAL ELIGIBLE SPECIAL NEEDS PLAN (CO D-SNP)

CO D-SNPs vary across states. A CO D-SNP may offer only Medicare covered benefits unless required by the state. Some target individuals with disabilities. Supplemental benefits may be used to drive enrollment, fill in gaps in Medicaid benefits, or to offer other types of support.

HIGHLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLAN (HIDE SNP)

The HIDE SNP requires a moderate level of coordination with Medicaid. HIDE SNPs are required to provide either MLTSS or behavioral health coverage, either directly or through a companion Medicaid managed care plan. Enrollment for a HIDE SNP may come from beneficiaries who receive Medicaid benefits from another managed care organization or fee-for service.

FULLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLAN (FIDE SNP)

The FIDE SNP requires a higher level of coordination with Medicaid. FIDE SNPs are required to provide both MLTSS and behavioral health coverage. A FIDE SNP is a single entity that provides access to combined Medicare and Medicaid benefits and holds both an MA contract with CMS and a Medicaid managed care contract.

Other Programs serving Dually Eligible Individuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE organizations provide comprehensive medical and social services to individuals who are 55 years of age or older and qualify for nursing facility level of care but choose to reside in the community. PACE is designed to enable most beneficiaries to remain in the community rather than a nursing home through its unique care team model. In addition to all Medicare and Medicaid services, PACE programs cover additional services including adult day care, nutritional counseling, social services, and respite care.

PACE organizations are not required to submit a Part C annual Bid Pricing Tool (BPT); although they do file a Part D BPT.

MEDICARE-MEDICAID PLAN (MMP)

The MMP is a demonstration program that CMS introduced in 2013 that includes a three-way contract between CMS, the state, and the MMP to provide all Medicaid and Medicare benefits. MMPs differ from SNPs in that they are totally aligned (i.e., all members get their Medicaid and Medicare services from the same health plan), improving the coordination between federal and state requirements. One goal of the MMP is to reduce financial misalignments that lead to poor quality and cost shifting.

MMPs are not required to submit BPTs.

With the April 2019 final rule, CMS is requiring all states with MMP programs to transition to alternative approaches that encourage coordination between the plans and states. States will have discretion whether to require HIDE, FIDE, or other types of arrangements. The following Table shows the number of states with beneficiaries covered under models specifically focused on serving dually eligible individuals and the number of beneficiaries covered by these organizations in 2023. A full table by state is included in Appendix A.

Table 1 – Models Serving Dually Eligible Individuals – Summary Counts for July 2023[4]

Model	CO -D-SNP	HIDE D-SNP	FIDE D-SNP	MMP	PACE
Number of States with Beneficiaries covered by the arrangement in 2023	39	17	12	8	33
Number of covered beneficiaries in 2023	2,977,878	2,113,906	417,257	317,648	56,385

Changes which made D-SNPs attractive to MAOs

The CMS Community Rating model, which began in the 2017 payment year, identified cost differentials between classes of the Medicare eligible population based on Medicaid Status. This segregation of the Medicaid statuses is consistent with the distinct cost profiles reported in the 'Evaluation of the CMS-HCC Risk Adjustment Model'[5] and adopted for payment year 2017[6] and beyond. The new payment model represents six community subgroups with distinct cost profiles[7], meaning that the risk score model is adjusted to more accurately reflect the cost difference between the subgroups or populations. For instance, the full duals had a predicted ratio <1.000 showing that risk score model used in 2010 and 2011 (the source year of Medicare 100% data) was under predicting actual costs. The new payment model reflected the higher costs associated with the Full dual population. The following table shows the relationship of the cost profiles to the Fee-for-Service (FFS) population.

Table 2 - Predictive ratios for Community Population, 2014 Model[6]

FFS population	1.000
Non-dual	1.015
Dual	0.957
Full benefit duals	0.914
Partial benefit duals	1.092
Source: RTI International analysis of 2010-2011 Medicare 100% data	

For the MAOs, using a D-SNP, each member identified as Full dual could be on a plan representing the risk model which reflects higher predicted costs associated with the population. Aggregating a cohort of members who qualify as Full benefit dual (higher risk score because of the new Community Rating model)

[4] https://www.cms.gov/https/wwwcmsgov/research-statistics-data-and-systems/statistics-trends-and-reports/monthly-enrollment-plan-2023-07

[5] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/evaluation_risk_adj_model_2011.pdf

[6] Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017

[7] The six community models are Full benefit dual aged, Full benefit dual disabled, Partial benefit dual aged, Partial benefit dual disabled, Non-dual aged, and Non-dual disabled.

impacts (increases) risk revenue. Higher revenue allows an MAO to richer benefits and improve its competitive position.

The new payment model meant that for every beneficiary classified as a Full benefit dual the MAO received a higher risk score payment. Although D-SNPs were an option open to MAOs, plans similar to D-SNPs were developed which did not meet the D-SNP requirements. D-SNP look-a-like plans were general enrollment plans but targeted dually eligible members. The look-a-like plans did provide the richer benefits that resulted from the higher revenue however, they did not meet the D-SNP requirements including not obtaining a SMAC, filing a Model of Care (MOC) or being subject to specific D-SNP reporting requirements. Under the final rule (42 CFR 422.514), the Centers for Medicare & Medicaid Services (CMS) no longer enters into a contract with a non-SNP plan that projects 80% or more of its enrollment will be entitled to Medicaid after 2021 for new plans and after 2022 for existing non-SNP plans. MA plans that had been active for less than one year and had enrollment of 200 or fewer individuals at the time of such determination are exempt from the rule[8,9]. Further, the limitation to D-SNP look-a-likes only applies in states where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as Medicare-Medicaid Plans (MMPs). As of 2020, D-SNPs operated in 42 states, the District of Columbia, and Puerto Rico.[10] The discontinuation of D-SNP look-a-like plans in the majority of states may further increase MAOs' interest in offering a true D-SNP.

How to start a D-SNP?

The following table represents the timing of notifying CMS of intention to initiate a D-SNP in contract year (CY) 2025 through the development of the bids and their filing with CMS.

Table 3 – Timeline of D-SNP Notifications

Approximate Date	Milestone
Early November 2023	Recommended date to submit Notice of Intent to Apply form to CMS
Early December 2023	CMS User ID form due to CMS
Early January 2024	Final Applications Posted by CMS
Mid-January 2024	Deadline for NOIA form submission to CMS
Mid-February 2024	Completed Applications due to CMS
April 2024	Plan Creation Module, PBP, BPT in HPMS
Early May 2024	PBP/BPT Upload Module in HPMS
Mid-May 2024	Release of CY 2025 Formulary Submission Module
Early June 2024	Bids due to CMS
Late August 2024	CMS completes review and approval of bid data
September 2024	CMS executes MA and MA-PD contracts with MAOs
Mid-October 2024	Annual Coordinated Election Period begins for CY 2025 plans

[8] https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf

[9] We note the requirement that a general enrollment plan must enroll at least 300 members by its third year to continue to be renewed by CMS remains and is not impacted by the D-SNP requirements or exceptions. Such general enrollment plans would not be exempt from the 300 member minimum requirement.

[10] https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf

For an existing MAO with an existing H-number with no service area expansion, only the D-SNP application is required[11] to be filed with CMS. A new MAO, new H-Number, or service area expansion will require the full application[12] and addition to the D-SNP application.

As part of the CMS D-SNP application, the MAO is required to submit a Model of Care (MOC). The MOC is intended to ensure that the clinical and non-clinical needs of enrollees will be met by the MAO. The National Committee for Quality Assurance (the NCQA) reviews and approves the MOC. Approval may be for one, two, or three years depending on its score.

In addition, the CMS application to offer a D-SNP includes providing CMS with the State Medicaid Agency Contract (SMAC) for each state in which the MAO intends to offer a D-SNP. The SMAC must be submitted to CMS in July of the year of the application filing, it is not due with the application. Generally, the SMAC requires the MAO to define the Medicaid status codes who will be eligible, confirming the Medicaid benefits are covered, the service area of the D-SNP, etc. Each SMAC includes the requirements for information sharing between CMS, the state's Medicaid plan, and the MAO. However, the SMAC specific requirements differ by state so the target state's Medicaid web site should be consulted.

Considerations

As evidenced by the predictive ratios, the expected cost for Full-dual members is higher than general enrollment beneficiaries that may be covered by the MAO. In addition, the SMAC may require the MAO to cover benefits beyond Medicare implying additional costs. Understanding those benefit requirements for each state is important to ensure the correct benefits are being provided to members as well as profitability of the plan.

REVENUE

A revenue source is required from a capitation or other payment to the MAO by some states for support of non-Medicare benefits. Understanding what funding is available from the state and reporting that funding is required.

Within the development of the Bids, the CMS Low Income Premium Subsidy Amount (LIPSA)[13] may be targeted as a Part D basis premium. Subsidy is available to qualified beneficiaries based on Medicare and Medicaid statuses, as well as income and assets. If a member does not qualify for the full LIPSA, the member would be required to pay the premium or the difference between the partial LIPSA and full LIPSA.

RISK SCORES

When developing a D-SNP plan, the Medicare Advantage Organization (MAO) must specify which categories of beneficiaries will be allowed to join the plan. The MAO may find it advantageous to combine all of the Full benefit duals (full-duals) in one plan and all of the Partial benefit duals (partial-duals) in

[11] https://www.cms.gov/files/document/medicare-advantage-duals-special-need-plan-application2024.pdf
[12] https://www.cms.gov/files/document/cy-2024-medicare-advantage-part-c-application.pdf-1
[13] Eligibility for the Low Income Premium Subsidy Amount (LIPSA) is updated annually by CMS based on a formula described in 42 CFR 423.772 of the MMA. See: https://ecfr.io/Title-42/Section-423.772

another plan. Or the MAO may find that combining all of the Medicaid eligible members in a single plan works best. Individuals with Medicaid statuses that are not included in a D-SNP would have a place within an MAO's general enrollment plan. Along with projected expenses (claims and non-benefit expenses), it is prudent for the MAO to consider risk scores, the impact of the community model on a D-SNP's risk score, and the revenue that will be generated.

The selection of the Medicaid status codes that identify the beneficiary population in a D-SNP drives the risk score model and, therefore, the projected risk score. Along with other Bid[14] parameters, the risk score drives the revenue and, ultimately, the margin.

As mentioned previously, the predictive ratio for the Partial benefit dual is >1.000 or lower cost than predicted so the risk score model will reflect the lower expected costs. A D-SNP plan may be offered to all or to a subset of the Medicaid categories. It is not unusual for Medicare Advantage Organizations (MAOs) to offer plans to 'Full Duals' – typically Medicaid statuses 02, 04, and 08 - or 'Partial Duals' – typically Medicaid statuses 01, 03, 05, and 06. Bringing the higher cost full benefit duals together in a D-SNP helps an MAO to maximize the predicted risk score and thereby offer a broader, richer array of supplemental benefits. For an MAO developing D-SNP plans, understanding the risk model associated with the population being targeted and striking a balance between the dual types is a key to managing benefits and profitability.

We note that in the 2024 Advance Notice[15], CMS announced a proposed Part C risk score model change. In the 2024 Final Rate Announcement[16], CMS finalized the 2024 proposed Part C risk adjustment model. The current and new risk score models are being referred to as 2020 CMS-HCC Model Risk Score (V24) and 2024 CMS-HCC Model Risk Score (V28) respectively. The V28 risk score model is being phased in over three years by increasing the weight of the V28 risk score by one third each year (i.e., for 2024, the risk score calculation is 2/3 x V24 + 1/3 x V28). In order to validate the differences discussed in this brief, results from V28 only are being shown so the risk scores shown in Table 4 represent the risk score after the phase-in to V28 is complete. During the phase-in period, the risk scores will differ from the results based on the pure V28 risk score model shown in Table 4 however, the relationship between the estimated risk scores for the different status codes is similar between V24 and V28.

Table 4 shows the impact of the MAO's definition of D-SNP eligibility on risk scores considering different combinations of Medicaid status. The three options outlined represent three different ways the eligibility for D-SNP plans could be set up by an MAO, while covering all active Medicaid statuses between all plans offered. The results based on V28 risk score model are shown at the bottom of the table.

[14] The Bid parameters are submitted to CMS the first Monday in June by way of the Bid Pricing Tools (BPTs). The BPTs include (non-exhaustive list), the A/B Bid, Rebate, Quality Rating (STARS), supplemental benefits, and member premium which drive revenue the MAO receives.
[15] 2024 Advance Notice | CMS
[16] 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) | CMS

Table 4 - Risk Score Impacts due to Different D-SNP Definitions by Medicaid Status

		Option 1		Option 2		Option 3
Status Code	Medicaid Status	Plan A (Considered Full Dual)	Plan B (Considered Partial Dual)	Plan C	Plan D	All Medicaid Eligible in One Plan
01	QMB Only		Y	Y		Y
02	QMB and Medicaid	Y		Y		Y
03	SLMB Only		Y		Y	Y
04	SLMB and Medicaid	Y			Y	Y
05	QDWI		Y		Y	Y
06	Qualifying Individual.		Y		Y	Y
08	Full Dual (Non-SLMB non-QMB)	Y			Y	Y
09	Other Dual w/o full Medicaid		Y		Y	Y
Risk Score Based on V28 Risk Model		1.1304	1.0057	1.0273	1.0975	1.0690

Raw Risk Score based on 5% Limited Data Set[17] (2021 FFS Medicare source)

Table 4 illustrates three options for defining which Medicaid status codes are eligible to join the MAO's D-SNP plan. Each option has a place for all the active Medicaid statuses[18]. Option 1 illustrates allocating beneficiaries to full-dual and partial-dual plans based on a traditional understanding of the Medicaid status. Plan A is identified as a full-dual plan and is comprised of Medicaid statuses that include paying Medicare cost sharing (02, 04, and 08). Plan B covers the Medicaid statuses associated with partial-duals (01, 03, 05, 06, and 09).

Under Option 2, Plan C includes Qualified Medicare Beneficiary without other Medicaid (QMB only) and QMB with full Medicaid (QMB Plus) (01 and 02). Plan D covers the balance of the Medicaid statuses so is a mix of full-dual beneficiaries (04 and 08) and partial-duals (03, 05, 06, 09).

Finally, Option 3 includes all Medicaid Statuses in one plan.

As is seen in Table 4, the expected risk score for a plan will change depending on the Medicaid membership included in the plan. Differences in the risk score are indicative of the differences in revenue. For the purposes of building a benefit plan, the higher risk scores translate to increased risk based revenue, which may allow the plan to offer rich benefits to attract members[19]. For any plan, an MAO should consider the impact of the risk score on the projected risk revenue and benefits that can be made

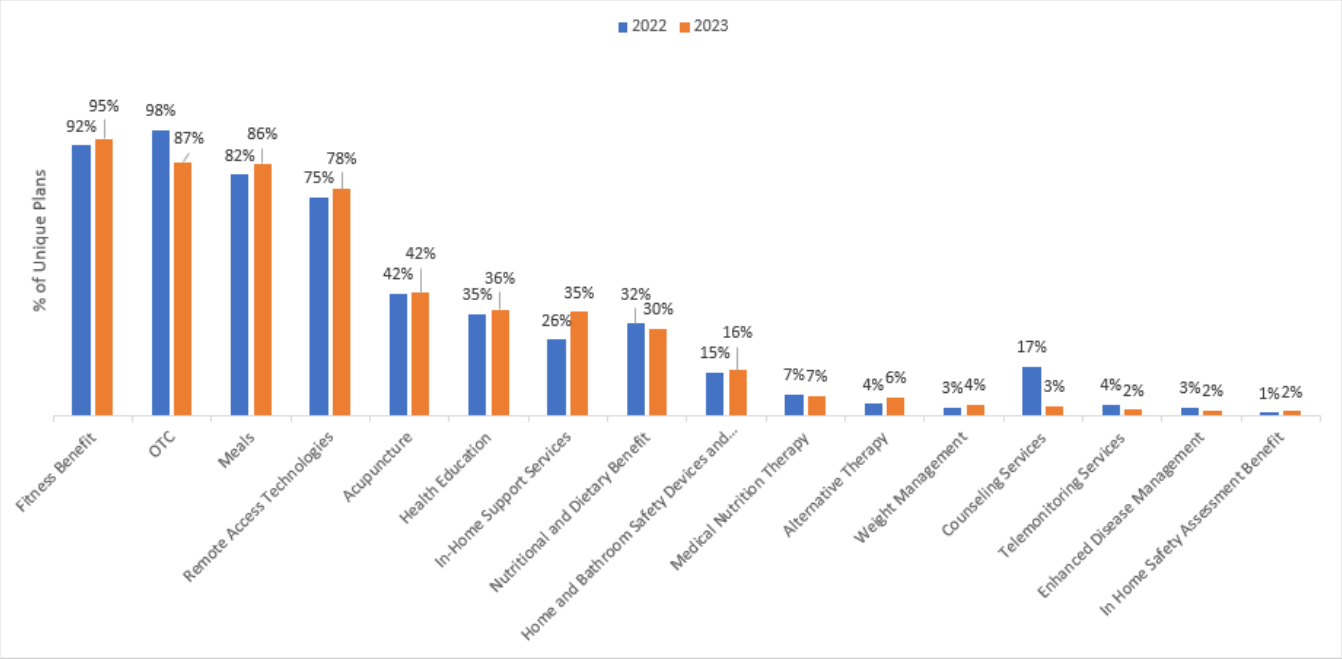
[17] The 5% Limited Data Set (LDS) is a 5% random sample of Medicare FFS claims data. The publicly available data have been stripped of data elements that might permit identification of beneficiaries. These files contain beneficiary level health information but exclude specified direct identifiers as outlined in the Health Insurance Portability and Accountability Act. For this analysis, data from the 2021 LDS was used.
[18] Medicaid status 07 is excluded because eligibility for 07 ended in 2002; Medicaid status 10 is excluded because the code is used with permission from CMS only.
[19] Other impacts to revenue include (but not limited to) the Part C Rebate, Part D Basic Premium, Part D Supplemental Premium, etc.

available to the beneficiaries. For a D-SNP, the Medicaid statuses included in the plan will impact the risk score but also indicate an expected difference in costs to be managed.

SUPPLEMENTAL BENEFITS

MAOs have found D-SNPs to be a profitable plan type resulting in dollars that can be used to provide supplemental benefits to support and attract members. The following table provides some insight into supplemental benefits being offered under special needs plans in CY 2023.

Table 5 - Special Needs Plans – Supplemental Benefits[20]



D-SNPs have several avenues for including supplemental benefits. Consistent with general enrollment plans, D-SNPs may use the rebate from the bid to cover supplemental benefits. To cover new kinds of benefits, Value-Based Insurance Design (VBID) allows the plan to offer benefits that are new to the marketplace and are expected to improve the member health or experience for a certain group within the membership of the plan (non-uniform benefits). More information is available at CMS Innovation Center Homepage | CMS Innovation Center. Outside of VBID, the plan may offer benefits focused on certain conditions through the Special Supplemental Benefits for the Chronically Ill (SSBCI).

Staying aware of the options available to MAOs to provide a variety of benefits to D-SNP members within a service area will ensure marketability. Future white papers will discuss the impact of VBID, SSBCI as well as other aspects of the Medicare Advantage program on D-SNPS as well as the impact of D-SNPs on an MAO's portfolio.

[20] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/benefits/2023-pbp-benefits-q2; https://www.cms.gov/httpswwwcmsgovresearch-statistics-data-and-systemsstatistics-trends-and/pbp-benefits-2022-updated-07012022

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OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

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Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

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Appendix A

Models Serving Dually Eligible Individuals Beneficiary Count by State – July 2023

State	CO D-SNP	HIDE D-SNP	FIDE D-SNP	MMP	PACE
AL	138,133	-	-	-	163
AK	-	-	-	-	-
AR	73,891	-	-	-	452
AZ	-	118,260	12,090	-	-
CA	399,822	-	21,259	-	13,445
CO	59,970	-	-	-	4,036
CT	93,207	-	-	-	-
DC	5,759	8,864	-	-	18
DE	14,154	-	-	-	310
FL	19,849	596,663	18,390	-	2,500
GA	222,945	-	-	-	-
HI	-	34,610	-	-	-
IA	38,995	-	-	-	565
ID	1,083	-	14,539	-	-
IL	-	-	-	96,235	-
IN	119,448	-	-	-	435
KS	-	22,522	-	-	739
KY	53,316	37,330	-	-	22
LA	156,989	-	-	-	350
MA	-	-	69,844	44,933	4,945
MD	33,969	-	-	-	143
ME	37,930	-	-	-	-
MI	129,415	-	-	43,747	4,412
MN	-	11,374	46,228	-	-
MO	100,098	-	-	-	39
MS	87,686	-	-	-	-
MT	5,368	-	-	-	-
NC	183,277	-	-	-	1,779
ND	-	-	-	-	169
NE	1,778	16,444	-	-	173
NH	-	-	-	-	-
NJ	-	-	90,897	-	1,090
NM	-	28,215	-	-	445
NV	23,762	-	-	-	-
NY	144,444	394,591	38,482	1,732	4,876
OH	180,820	-	-	73,650	523
OK	49,786	-	-	-	635
OR	4,593	31,909	-	-	1,611
PA	165,139	17,651	50,067	-	7,194
PR	-	298,732	-	-	-

State	CO D-SNP	HIDE D-SNP	FIDE D-SNP	MMP	PACE
RI	14,973	-	-	13,471	345
SC	88,294	-	-	11,964	447
SD	3,449	-	-	-	-
TN	140,063	-	1,823	-	272
TX	95,878	284,649	-	31,916	1,071
UT	19,683	-	-	-	-
VA	14,240	32,429	51,060	-	1,489
VT	-	-	-	-	-
WA	17,083	97,524	-	-	1,217
WI	25	82,139	2,578	-	475
WV	36,601	-	-	-	-
WY	1,963	-	-	-	-
Total	2,977,878	2,113,906	417,257	317,648	56,385

https://www.cms.gov/https/wwwcmsgov/research-statistics-data-and-systems/statistics-trends-and-reports/monthly-enrollment-plan-2023-07