Tips for States on Working with Dual Eligible Special Needs Plans to Improve Coordination of Physical and Behavioral Health Services for Dually Eligible Individuals

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Behavioral health conditions are common among dually eligible individuals. About half of all full-benefit dually eligible individuals reported having a mental health condition - twice as many as non-dually eligible Medicare enrollees.[1] In particular, dually eligible individuals under the age of 65 in particular have high rates of anxiety, depression, bipolar disorder, and/or schizophrenia and other psychotic disorders.[2] Having a mental health condition also makes dually eligible individuals more likely to experience physical health comorbidities, such as heart conditions, stroke, lung disease, diabetes, and other metabolic disorders.[3] Additionally, more than one in ten dually eligible individuals have a substance use disorder.[4]

ABOUT THIS TIP SHEET

This tip sheet details strategies states can use in their State Medicaid Agency Contracts (SMACs) with Dual Eligible Special Needs Plans (D-SNPs) to promote integration and coordination of behavioral health benefits among enrolled dually eligible individuals. This tip sheet also highlights how a few D-SNPs have gone beyond the SMAC requirements to further promote behavioral health integration.

Dually eligible individuals with both physical and behavioral health conditions must not only navigate the separate physical and behavioral health systems, but they must also navigate the separate Medicare and Medicaid administrative and payment systems and their varying coverage of health services. These bifurcated systems often produce uncoordinated care that can leave dually eligible individuals facing service gaps, duplication of care and services, and/or potentially dangerous prescription drug interactions. Medicare and Medicaid spending for dually eligible individuals with behavioral health disorders is at least double that of dually eligible individuals without these conditions,[5] likely at least in part due to this disconnected system of service delivery.

States can work collaboratively with Dual Eligible Special Needs Plans (D-SNPs) – specialized Medicare Advantage plans designed specifically for dually eligible individuals – to improve coordination of Medicare and Medicaid physical and behavioral health services for D-SNP enrollees. Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) and Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) are types of D-SNPs that typically cover Medicaid behavioral health services, in addition to covering all Medicare services. Starting in 2025, all FIDE SNPs must cover Medicaid behavioral health services.[6] All D-SNPs must at least coordinate Medicare and Medicaid services for their enrollees, such as by helping them to understand and access the Medicaid behavioral health services for which they qualify.[7] D-SNPs can also design their Models of Care to offer holistic, person-centered care coordination that includes involvement of both primary care and behavioral health providers in enrollees' integrated care teams to jointly address enrollees' medical and behavioral health needs.[8]

A FIDE SNP or HIDE SNP designation, however, does not necessarily mean that a particular D-SNP is delivering physical and behavioral health services in a coordinated manner. States can encourage D-SNPs to advance coordination by incorporating specific requirements into their State Medicaid Agency Contracts (SMACs) with D-SNPs and monitoring D-SNPs' compliance with those requirements.

In this tip sheet, we summarize several contracting strategies that states can use to promote improved coordination of physical and behavioral health services for D-SNP enrollees.

State D-SNP Contracting Strategies to Improve Coordination of Physical and Behavioral Health Benefits for D-SNP Enrollees with Behavioral Health Conditions

To learn more about how states are using contracting strategies to improve the coordination of physical and behavioral health benefits for D-SNP enrollees with behavioral health conditions, the Integrated Care Resource Center (ICRC) conducted interviews with staff from five state Medicaid agencies and health plans from three of these states.[9] We also reviewed all states' 2023 SMACs. We identified the following six D-SNP contracting strategies that states currently use to promote coordination of physical and behavioral health services.

Strategy 1: Behavioral Health Training Requirements for D-SNP Care Coordinators, Peer Support Staff, and Other Providers

States may require D-SNP care coordinators to have the appropriate professional background and training in behavioral health. Professional credentials vary by state and can be inclusive of behavioral health professionals of various educational backgrounds. For example, a D-SNP care coordinator may hold a degree/license in social work, psychology, counseling, or another credential that requires less formal academic training, such as an Associate in Social Work (ASW).

Furthermore, states can require all care coordinators, peer support staff, and other providers to undergo specialized training, such as learning effective communication strategies in connecting with those who have certain behavioral health needs. Massachusetts, for example, requires D-SNPs to comply with its Frail and Elder Waiver requirements for peer support staff to complete a Certified Older Adults Peer Specialists (COAPS) training to support staff who work in a variety of settings, such as adult day centers, older adult housing units, and health clinics.[10] This training is specifically designed for staff supporting older adults with behavioral health needs and focuses on specific behavioral health concerns and co-occurring physical health concerns related to aging. The training covers topics related to cultural competence, anxiety, depression, trauma, substance use, and how to use concepts such as stages of change theory to support behavior change.[11,12] Starting in 2026, Massachusetts will require its D-SNPs to provide training for their primary care providers (PCPs) on the use of mental health and substance use disorder screening tools, instruments, and procedures for adults so that PCPs proactively identify behavioral health service needs early and offer enrollees referrals to behavioral health services when clinically appropriate.[13] Other training requirements could

include training on Medicare and Medicaid coverage of behavioral health services, including the specific benefits covered under an enrollee's D-SNP and Medicaid coverage in their state, and how to access those benefits.

Additionally, states can require training for care team staff on how to use admissions data (e.g., encounter data, utilization data) to improve screening and better identify enrollees who may have behavioral health needs. This training can support staff in making sure care coordinators connect enrollees to the appropriate behavioral health services early and continuously, which may include being assigned to a different care coordinator or other health care professional with the appropriate behavioral health background and/or training.

Box 1. Going Beyond the Requirements: Assigning a Specialized Behavioral Health Care Clinician

In Massachusetts, Commonwealth Care Alliance (CCA) operates a Medicare-Medicaid Plan that enrolls dually eligible individuals under age 65 and a fully integrated D-SNP (FIDE SNP) that enrolls dually eligible individuals over age 65. In both plans, enrollees with designated levels of behavioral health needs are assigned to a specialized behavioral health clinician who is embedded in the care team, manages all the enrollee's behavioral health services, and regularly communicates with the enrollee's care team. Behavioral health clinicians also work with care partners and community clinicians as well as other staff on how to guide an enrollee through accessing services. CCA reports that the enrollee experience and available services are identical in both plans, with one unified case management team for both.

Strategy 2: Behavioral Health-Specific Interdisciplinary Care Team Requirements

All Medicare Advantage Special Needs Plans, including D-SNPs, must use Interdisciplinary Care Teams (ICTs) to address enrollees' health and functional needs.[14] States can require D-SNPs to include certain types of providers in their ICTs for enrollees with behavioral health needs to ensure communication and collaboration among all of an enrollee's providers.

Tennessee requires that FIDE SNPs operate an integrated clinical model and ICTs that consist of nurse practitioners, social workers, registered nurses and/or licensed practical nurses, and licensed behavioral health clinicians who coordinate care across enrollees' Medicare and Medicaid benefits, regardless of payer.[15] Idaho requires that D-SNPs include a care coordinator, PCP, and a behavioral health clinician in the ICT for enrollees with behavioral health needs.[16]

New Jersey requires D-SNPs to include Medicaid Behavioral Health Home (BHH)[17] staff in all ICT meetings, care plan development, and enrollee care planning to streamline care plan integration. BHH core team staff include a nurse care manager, a care coordinator, a health and wellness educator, and consultative services provided by a psychiatrist and a primary care physician who provide comprehensive care management, care coordination, health promotion, individual and family support services, and transitional care.[18] Integration of behavioral health providers in enrollees' ICTs can further streamline communication between enrollees' providers and reduce duplication in care planning.

Strategy 3: Early Intervention Through D-SNP Health Risk Assessments

Early recognition and treatment for behavioral health conditions can prevent complications, improve quality of life, and help reduce health care costs.[19] States can encourage early intervention and increased behavioral health screening practices by requiring D-SNPs to incorporate behavioral health-related assessment questions into their Health Risk Assessments (HRAs). Minnesota, for instance, requires its highly integrated D-SNPs (HIDE SNPs) to include questions specifically about behavioral health needs in their annual HRA and will soon require plans to switch to using the state health assessment online application (MnCHOICES) that includes behavioral health screening questions.[20]

States can specify in their data use agreements and SMACs that D-SNPs must share HRA data in accordance with 42 Part 2 Confidentiality of Substance Use Disorder Confidentiality Records.[21] Further, states can specify when and how that information will be used. States that include HRA data in state integrated data systems can then use the information proactively. For example, state Medicaid agencies can share the information from the HRA with the enrollee's providers so they can detect behavioral health conditions earlier and ensure that enrollees are connected to the appropriate care coordinator (see Strategy 1).

Box 2. Going Beyond the Requirements: Behavioral Health Assessments

In Massachusetts, Commonwealth Care Alliance's D-SNP conducts an enhanced assessment when an individual enrolls to identify any behavioral health needs. Initial assessments have questions surrounding substance use, social determinants of health, and other behavioral health symptoms. If the plan has prior knowledge of an enrollee's behavioral health needs (usually based on claims data), the plan will have both a behavioral health professional and a nurse conducting the assessment. If only a nurse is doing the assessment and determines the enrollee has significant behavioral health symptoms that need to be addressed quickly, a behavioral health professional can be brought in (including Psychiatric Nurse Practitioners) for hands-on, immediate assistance.

Strategy 4: Care Coordination During Crisis Response and Transitions of Care

Effective coordination while an enrollee is experiencing a crisis or a major care transition is key to responding to an enrollee's needs in real time and to sustaining their long-term behavioral health care coordination. To further advance crisis response coordination and procedures, states can require D-SNPs to develop crisis response protocols to respond to urgent behavioral health needs and connect plan enrollees to the appropriate behavioral health providers during a crisis event.

Idaho requires its D-SNPs' nurse advice lines to assist and triage callers who may be in crisis by "warm transferring" plan enrollees to a licensed behavioral health clinician.[22] Oregon requires D-SNPs to have a "collaborative discharge plan" that entails working with behavioral health providers, the ICT, primary care, specialists, other partners. Oregon requires D-SNPs to work with Medicaid managed care plans and discharging facilities to have a "collaborative discharge plan" to prevent avoidable hospitalizations or unnecessary readmissions. For D-SNP enrollees who have had a hospital stay, emergency department visit, voluntary or involuntary psychiatric care, or other in-patient admission, the collaborative discharge plan entails working with behavioral health providers, the ICT team, PCP, specialists, the state's care coordination contractor, and other state partners. [23] D-SNP requirements

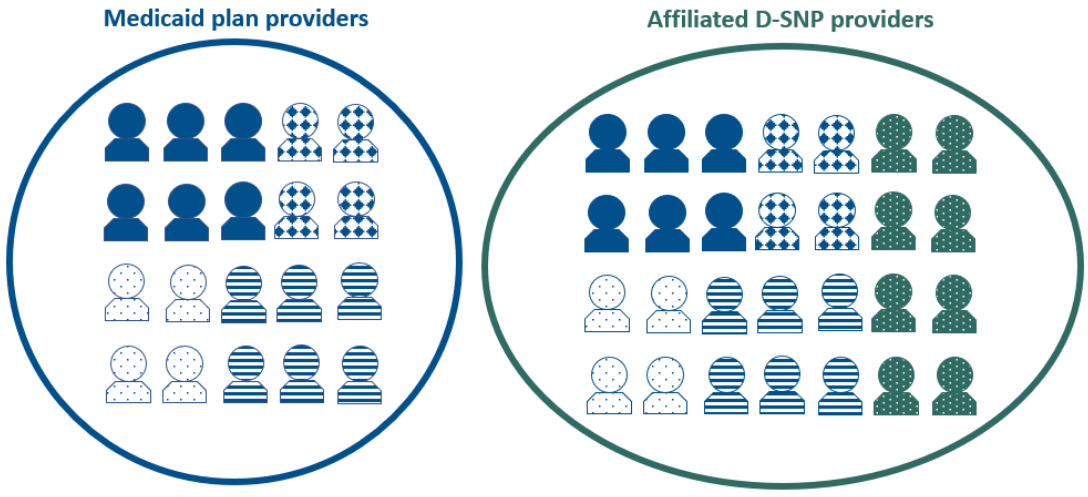
that outline specific behavioral health crisis response protocols and communication plans can expedite response times, inciting prompt care and improved health outcomes.

Strategy 5: Inclusion of Medicaid Behavioral Health Providers in Provider Directories and Alignment of Behavioral Health Provider Networks

Navigating and accessing behavioral health providers can be burdensome and confusing for enrollees, especially when they must navigate separate Medicare and Medicaid providers. States can simplify an aligned enrollee's search for providers by requiring D-SNPs to develop and maintain a provider directory that includes both Medicaid and Medicare behavioral health providers, instead of requiring enrollees to search through two separate directories. Tennessee, for example, asks its D-SNPs to develop and maintain an integrated Medicare-Medicaid provider directory online, which includes behavioral health providers as well as other long-term supports and services (LTSS) providers.[24] Having one set of providers to choose from may streamline an enrollee's process of identifying the right providers for them.

Washington has been working with its D-SNPs and their affiliated Medicaid managed care plans to promote provider network alignment. The goal of this effort is to increase access to care and coordination of Medicare and Medicaid benefits within its integrated care plans, as well as continuity of care for people who transition from having only Medicaid benefits (and coverage through a Medicaid managed care plan) to being dually eligible and qualifying for the state's integrated D-SNPs. Starting January 1, 2025, Washington will require its D-SNPs to have 80 percent of the D-SNP's affiliated Medicaid managed care plan's network providers in the D-SNP's Medicare network **(Figure 1).** The state includes in the 80 percent alignment requirement any provider types that are included in CMS network adequacy requirements, including acute, primary, and behavioral health providers.

Figure 1. Washington Provider Network Alignment Requirement for D-SNPs



Washington has worked with its D-SNPs toward achieving this 80 percent alignment requirement over time, with the goal of achieving a 95 percent alignment requirement in the future. First, the state required its D-SNPs to report on the percentage of the Medicaid plan's network providers that were also included in the D-SNP's Medicare network, stratified by provider type. The goal of this reporting

requirement was to enable the state to identify provider types where the plans' provider network alignment was below 80 percent. Next, the state began offering marketing incentives and template materials to the D-SNPs where greater alignment was needed – for example, when a pair of affiliated plans met the state's provider network alignment goal, the state allowed those plans to market their D-SNP product to the Medicaid plan enrollees who were becoming eligible for Medicare. D-SNPs that do not meet the 80 percent alignment requirement will face corrective action plans and marketing limitations. However, in 2024, D-SNPs that have 95 percent provider network alignment will be allowed to conduct default enrollment. [25,26]

Strategy 6: Collaborative Data-Sharing Platforms and Procedures

States have opportunities to improve monitoring and sharing of physical and behavioral health claims data and provider information across Medicare and Medicaid by requiring D-SNPs to use collaborative data-sharing practices and platforms. Massachusetts, for instance, requires its D-SNPs to document and monitor behavioral health referrals in the enrollee's Centralized Enrollee Record (CER) and make timely data entries about the behavioral health assessment, diagnosis determined, medications prescribed, and any individualized plan of care.[27] The state requires its D-SNP to ensure the CER data are available to all specialty, long-term care, mental health, and substance use disorder providers to promote collaboration across provider types.[28]

Prescription medication can be a critical intervention for those with behavioral health needs, and therefore states may want to consider requiring D-SNPs to share medication information across providers and/or with the state to monitor any improper or inadequate use, or dangerous drug interactions. For example, Indiana requires its D-SNPs to send the state the weekly Medicare Part D Pharmacy claims that have been submitted to CMS. Indiana uses the data for internal review and monitoring of the health of the dually eligible population (including the development of a dashboard to monitor pharmacy use), and to help support D-SNPs in providing Part D benefits. The state intends to use the D-SNP Part D Pharmacy data to compare utilization rates among Medicare-only, Medicaid-only, and dually eligible individuals. In addition, the state will share Medicare data reports on dually eligible individuals related to behavioral health and opioid use risk, high risk medication use, opioid prescribing patterns, and other reports with D-SNPs. D-SNPs in Indiana are expected to share the information with their Medicaid managed care plan counterparts in order to support care coordination for dually eligible individuals.[29]

Box 3. Going Beyond the Requirements: Leveraging Collaborative Data-Sharing Platforms

CareOregon (which operates a D-SNP in Oregon) is going beyond the state's SMAC requirements to leverage collaborative data-sharing platforms. For example, CareOregon's D-SNP has a cloud-based software platform that can be accessed by network providers. Currently, providers and primary care clinics can log in to an enrollee's profile and see behavioral health claims and thus determine if the enrollee is receiving services from a behavioral health provider. The plan is working on allowing behavioral health providers to log in to the portal as well and see an enrollee's primary care provider information.

Mercy Care is working on providing access to a single data platform where Mercy Care clinical staff, identified family enrollees/guardians, and physical and behavioral health providers can upload and review notes, and coordinate an enrollee's care. Additionally, the application provides access to all claims and pharmacy data.

Conclusion

Dually eligible individuals with physical and behavioral health conditions must often navigate both physical and behavioral health systems and siloed Medicare and Medicaid payment systems simultaneously. The absence of coordinated care can result in dually eligible individuals facing gaps in services, service duplication, and/or potentially dangerous prescription drug interactions.

We identified six contracting strategies that states are using to promote better coordination of behavioral health services: 1) adding behavioral health-related training requirements for care coordinators; 2) requiring behavioral health professionals in ICTs; 3) incorporating behavioral health assessments into HRAs; 4) developing crisis response protocols; 5) maintaining integrated provider directories that include behavioral health providers and aligning behavioral health providers across Medicare and Medicaid; and 6) requiring plans to use a collaborative data sharing platform accessible to payers, providers, and/or the state.

States can incorporate the requirements described above into their SMACs with D-SNPs to improve coordination of physical and behavioral health services for D-SNP enrollees. In addition, states should also engage dually eligible individuals with behavioral health needs to understand the best ways to continuously improve their ability to access the care they need.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the Integrated Care Resource Center are coordinated by Mathematica and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

[1] In 2020, among dually eligible individuals under 65 enrolled in fee-for-service Medicare, 34 percent had a diagnosis of anxiety disorder, 15 percent had a diagnosis of bipolar disorder, 33 percent had a diagnosis of depression, and 13 percent had a diagnosis of schizophrenia and other psychotic disorders. Medicare. Kaiser Family Foundation. "A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)." January 13, 2023. Available at: https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/

[2] Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. "Data Book. Beneficiaries Dually Eligible for Medicare and Medicaid." Exhibit 8. February 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/02/Feb23_MedPAC_MACPAC_DualsDataBook-WEB-508-SEC.pdf

[3] Centers for Medicare & Medicaid Services. "Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees." September 2014. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf.

[4] Legal Action Center. "Two Plans Are Not Always Better Than One: Barriers to Substance Use Disorder Treatment for Dual-Eligible Individuals." January 2024. Available at: https://www.lac.org/assets/files/Duals-Issue-Brief-2024.01.19_MAPP-Branded.pdf.

[5] Kelly, L. and Herman Soper, Michelle. "Coordinating Physical and Behavioral Health Services for Dually Eligible Members with Serious Mental Illness." Center for Health Care Strategies, June 2019. Available at: https://www.chcs.org/resource/coordinating-physical-and-behavioral-health-services-for-dually-eligible-members-with-serious-mental-illness/.

[6] Per 42 CFR 422.2. "Definitions."

[7] Weir Lakhmani, E. "Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025." Integrated Care Resource Center, June 2023. Available at: https://integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023

[8] For more information about the D-SNP Model of Care, see the Centers for Medicare & Medicaid Services' resource page: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.

[9] We interviewed three health plans (Commonwealth Care Alliance (CCA), CareOregon and Mercy Care) because of their long history and experience with integrated care and care coordination for the dually eligible population. Based in Massachusetts, CCA was established in 2003 and focuses on integrated care for older individuals and individuals with disabilities. It has been operating comprehensive health plans for dually eligible individuals for almost 20 years. Based in Oregon, CareOregon was founded in 1994 and provides Medicaid managed care services to individuals across eligibility groups. It established its first plan for dually eligible individuals in 2006. Based in Arizona, Mercy Care was established in 1985 and focuses on integrated care for Medicaid eligible individuals with complex health needs, including dually eligible individuals.

[10] SCO Appendix R, Exhibit 2, "Application for a §1915(c) Home and Community-Based Services Waiver." March 1, 2023. Available at: https://www.mass.gov/doc/sco-appendix-r-exhibit-2-frail-elder-waiver-20230301/download.

[11] Stages of Change is a specific model that behavioral health practitioners use to evaluate an individual's desire to change a specific behavior (such as quit smoking, quit drinking, reduce caloric intake to improve diabetes etc.) to determine what clinical intervention/strategy should be used. The stages are precontemplation, contemplation, preparation, action, maintenance, and termination. Trainings on the stages of change help practitioners determine what stage an individual is in and how to focus treatment accordingly.

[12] Commonwealth of Massachusetts. "Certified Older Adult Peer Specialist Training." Available at: https://www.mass.gov/certified-older-adult-peer-specialist-training

[13] Massachusetts EOHHS SCO Medicaid Contract, 2026, Section 2.9.10.3.1 and Massachusetts EOHHS One Care Medicaid Contract, 2023 Section 2.9.10.3.1. Available at: https://www.mass.gov/doc/2023-sco-model-contract-0/download.

[14] The minimum elements for SNP ICTs are described at 42 CFR 422.101(f)(1-3).

[15]Tennessee Department of Finance and Administration, Division of TennCare and UnitedHealthcare Plan of the River Valley, Inc. State Medicaid Agency Contract, 2023, Attachment F.4.d. Available at: https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html

[16] Idaho Medicare Medicaid Coordinated Plan, 2023 Additional Terms to Medicaid Provider Agreement, State Medicaid Agency Contract H1350, 2023, Appendix L. Section A.G.a. (Not available online.)

[17] The Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. More information on Health Homes available at: https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html

[18] New Jersey Department of Human Services, Division of Medical Assistance and Health Services and Oxford Health Plans (NJ). Inc. State Medicaid Agency Contract H3113, 2023, Section 10.4.4F and Appendix. (Not available online.)

[19] Mulvaney-Day, N., Marshall, T., Downey Piscopo, K. et al. "Screening for Behavioral Health Conditions in Primary Care Settings: A Systematic Review of the Literature." *Journal of General Internal Medicine*, Volume 33, 335–346 (2018). Available at: https://doi.org/10.1007/s11606-017-4181-0

[20] Minnesota Department of Human Services and Health Partners, Inc. State Medicaid Agency Contract, 2024, Section 6.1.5. Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp

[21] For more information, see CFR 42 Part 2. "Confidentiality of Substance Use Disorder Patient Records." Available at: https://www.ecfr.gov/current/title-42/part-2.

[22] Idaho Medicare Medicaid Coordinated Plan, 2023 Additional Terms to Medicaid Provider Agreement, State Medicaid Agency Contract H1350, 2023, Appendix C. Section M. (Not available online.)

[23] Oregon Health Authority and ATRIO Health Plans, Inc. State Medicaid Agency Contract H3814, 2023, Section 4.H.7.d. (Not available online.)

[24] Tennessee Department of Finance and Administration, Division of TennCare and UnitedHealthcare Plan of the River Valley, Inc. State Medicaid Agency Contract 2023, Attachment G, Section 5. Available at: https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html

[25] Based on conversations with Washington State Medicaid agency staff.

[26] For more information on default enrollment, see the ICRC fact sheet, "Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries," updated July 2019, available at: https://www.integratedcareresourcecenter.com/sites/default/files/Default_Enrollment.pdf.

[27] Behavioral health data sharing must be compliant with CFR 42 Part 2. "Confidentiality of Substance Use Disorder Patient Records."

[28] Massachusetts EOHHS SCO Medicaid Contract State Medicaid Agency Contract 2026, Section 2.15.5.6 and Massachusetts EOHHS One Care Medicaid Contract (State Medicaid Agency Contract, 2026, Section 2.15.5.6), available at: https://www.mass.gov/doc/2023-sco-model-contract-0/download .

[29] Indiana Family & Social Services Administration, Office of Medicaid Policy and Planning and Humana Benefit Plan of Illinois Contract, 2024, Exhibit 1.A. Section 5.A.3. Available at: https://www.in.gov/medicaid/partners/medicaid-partners/dual-eligible-special-needs-plans/; and conversations with Indiana State Medicaid Agency staff.