ICRC | Integrated Care Resource Center

State considerations for expanding D-SNPs into rural areas

ICRC State D-SNP Contracting Call

July 8, 2026

Logistics

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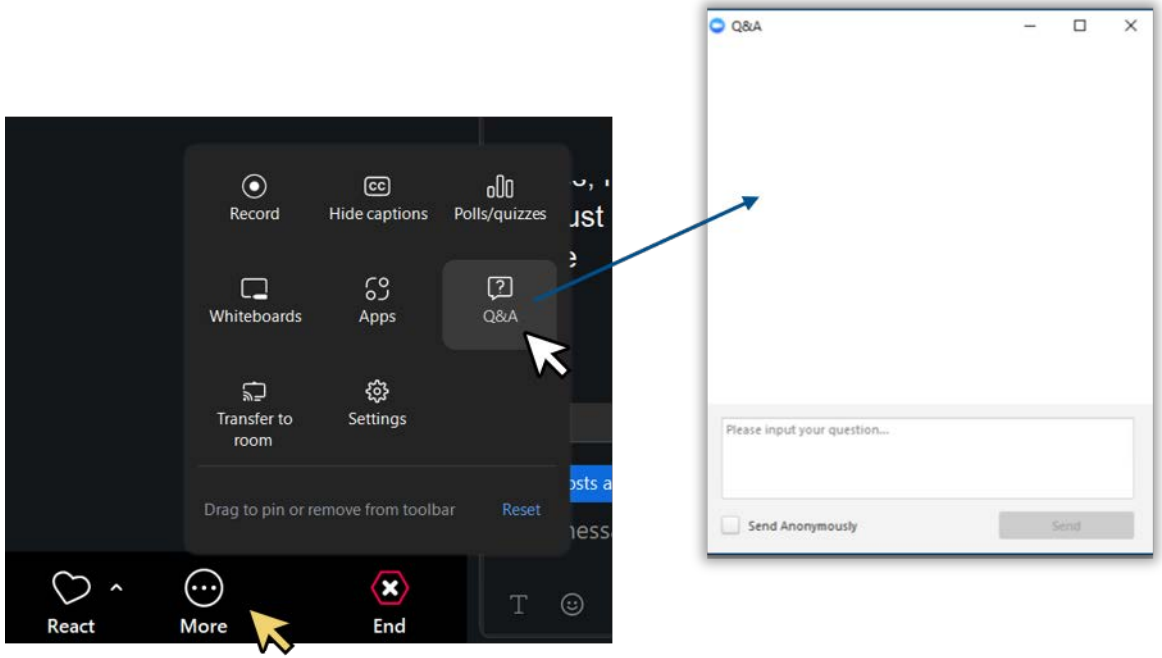

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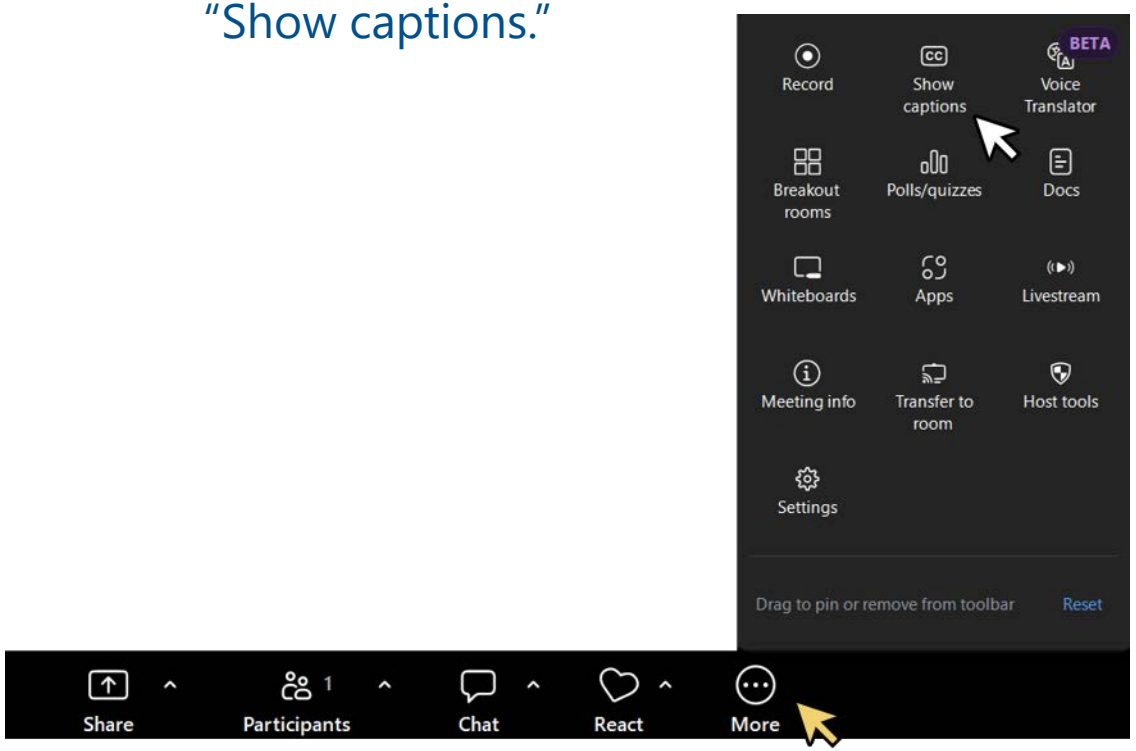

Agenda

- Welcome and introductions
- Background
  - Advancing state goals to increase access to integrated care
  - Challenges with D-SNP expansion in rural areas
  - Opportunities for states to expand dual eligible special needs plans (D-SNPs) in rural areas
- Discussion

Background

Advancing state goals to increase access to integrated care

- State efforts to advance Medicare-Medicaid integration for dually eligible individuals **need to include specific considerations for populations residing in rural areas.**
  - Of the approximately 2.7 million dually eligible individuals who live in rural areas, only about one in four have access to meaningful integration options, compared to the nearly two-thirds of dually eligible people in more urban areas.
- Under the 2025 budget reconciliation bill, the **Rural Health Transformation (RHT) Program** is allocating $50 billion over five years to states to improve health care access, quality, and outcomes in rural areas.
  - States can use integrated Medicare-Medicaid models to advance RHT Program priorities around sustainable access, appropriate care availability, and innovative care by aligning related investments with these key RHT program goals.

For more information, see M. Knowles, N. Joseph, N. Archibald, and E. Breslin. "Expanding Access to Integrated Medicare-Medicaid Programs in Rural Communities." Center for Health Care Strategies. August 2025. Available at: https://www.chcs.org/resource/expanding-access-to-integrated-medicare-medicaid-programs-in-rural-communities/

For more information on the Rural Health Transformation Program, see CMS' webpage at: https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview

Challenges with D-SNP expansion in rural areas

- D-SNPs often **struggle to meet network adequacy requirements** in rural areas with limited providers.
  - Federal requirements for provider network adequacy set at **42 CFR 422.116**.
  - **CMS uses maximum travel time and distance standards for Medicare Advantage plans** that vary by five geographic designations: Counties with Extreme Access Considerations, rural, micropolitan, metropolitan, and large metropolitan.
- Plans **may be reluctant to operate in low-population areas** if they believe they will not reach sustainable enrollment or face challenges interacting with rural providers.
  - Upfront investments are needed to implement a D-SNP in a new area, so plans entering rural service areas **need assurance that enrollment will be sufficient to yield a return on their investment**.
  - **Rural providers often face financial barriers to invest in the technologies** needed to build information and data exchange capabilities in support of care management.

Source: CMS. (2024, December). 2025 *HSD reference file*. [Excel spreadsheet] Retrieved on July 14, 2025 from https://www.cms.gov/files/document/2025-hsd-reference-file-updated-12032024.xlsx

Opportunities for states to expand D-SNPs in rural areas

- **Leverage contracts with D-SNPs to expand into rural areas.** States can include requirements for D-SNPs to cover rural areas and apply specific strategies for serving rural communities.
  - **Require D-SNPs to operate statewide.** States can require D-SNPs to operate statewide or selectively contract with D-SNPs to operate in specific regions, including in rural areas.
  - **Require D-SNPs to work with local entities**. States can strengthen provider networks and care coordination by requiring that D-SNPs collaborate with local rural entities to help them meet federal and state requirements for provider networks, care management, and care teams.
  - **Support or require D-SNP use of community-based workforce.** States can require that D-SNPs include community health workers (CHWs) in their provider networks to improve outreach and engagement for rural enrollees and fill workforce gaps impacting dually eligible individuals in rural areas.
  - **Implement policies to boost enrollment.** While states cannot require dually eligible individuals to enroll in D-SNPs with affiliated Medicaid MCOs, state implementation of default enrollment can help D-SNPs in rural communities to build enrollment over time.

For more information, see M. Knowles, N. Joseph, N. Archibald, and E. Breslin. "Expanding Access to Integrated Medicare-Medicaid Programs in Rural Communities." Center for Health Care Strategies. August 2025. Available at: https://www.chcs.org/resource/expanding-access-to-integrated-medicare-medicaid-programs-in-rural-communities/

Discussion

Discussion questions

- What challenges have you experienced in establishing successful D-SNP contracts in rural areas?
- What strategies have helped you expand D-SNPs into rural areas in your state?
- How does your state:
  - Identify access issues in rural areas that impact dually eligible individuals, or subpopulations of duals (e.g., LTSS, behavioral health)?
  - Engage with D-SNPs and other relevant entities (such as health care providers, dually eligible individuals, or beneficiary advocacy organizations) to address challenges in rural communities?
- Are any states are using Rural Health Transformation Program (RHTP) funding to bolster D-SNP penetration in rural areas? If so, how?
- What flexibilities, resources, or support do you need in this area?

Next steps (1 of 2)

Next steps (2 of 2)

- Send updates/changes in state D-SNP points of contact to ICRC@mathematica-mpr.com
- Send feedback or topics/questions for future calls to ICRC@mathematica-mpr.com

ICRC Is Here to Help

Interested in advancing integration?
ICRC is available to provide one-on-one technical assistance to states seeking to better integrate care for their dually eligible populations.

Email ICRC@mathematica-mpr.com

Thank you!

ICRC | Integrated Care Resource Center