

Managing Dual Eligibles Under Work Requirements: What D-SNPs and States Must Do

Operational strategies for serving the most complex population facing the most complex policy

Article 6A examined the expansion dual challenge: how work requirements affect the few hundred thousand people who entered Medicaid through expansion before qualifying for Medicare disability. While most of the 13.7 million dual eligibles are automatically exempt through SSI or age, this small subset faces unprecedented coordination complexity. The analysis described the problem. This article addresses the solutions: what Dual Eligible Special Needs Plans and states must actually do in the next 14 months to serve expansion duals effectively.

The operational challenge is real. D-SNPs built business models and care systems assuming enrollment stability. States designed Medicaid systems before Medicare-Medicaid integration became priority. Work requirements force both to adapt systems designed for different purposes to serve new functions. The adaptation is possible. It requires deliberate choices, substantial investment, and sustained coordination between organizations that rarely collaborate seamlessly.

The critical context: most D-SNP members are traditional duals automatically exempt from work requirements. Approximately 5.8 million people are enrolled in D-SNPs nationally. The vast majority entered Medicaid through SSI or age pathways providing automatic exemptions. Expansion duals likely represent 2-5 percent of total D-SNP enrollment nationally, with higher concentrations in specific plans serving younger disabled populations in expansion states. This article focuses on strategies for serving that expansion dual minority while acknowledging that most D-SNP operations continue with minimal work requirement impact.

D-SNP Risk Stratification: Knowing Your Population

The Four-Category Framework

Strategic insight: Accurate population segmentation is the foundation. Treating all dual eligibles identically wastes resources on those not at risk while under-serving those facing documentation barriers.

The first task is understanding which dual eligibles face work requirements and what support each needs. The vast majority of duals face no work requirement exposure whatsoever. Traditional duals entered Medicaid through disability or age pathways that provide automatic exemptions. Approximately 38 percent receive SSI, most others are over 60. These populations face no work requirements and need no additional support.

D-SNPs must segment enrolled duals into actionable categories.

Category one (vast majority): traditional duals over 65 or receiving SSI disability benefits. Automatic exemption through SSI or age. No work requirement exposure. Standard care coordination proceeds without modification.

Category two (tiny minority): expansion duals who entered Medicaid via income before qualifying for Medicare disability. Likely exempt through medical frailty but requires separate documentation with state. Priority for exemption documentation support.

Category three (rare): expansion duals under 65 who qualified for Medicare through paths other than disability where work capacity remains unclear. Need assessment of employment status, caregiving

responsibilities, education enrollment, or other exemption qualifying conditions. Category four (ambiguous): partial benefit duals in Medicare Savings Programs only. Unclear whether work requirements apply to Medicaid-only benefits. Monitor state policy decisions.

Most D-SNPs will discover category one comprises 90-95 percent of their dual eligible enrollment. Category two might represent 2-5 percent. Categories three and four combined rarely exceed 3 percent. The segmentation matters because treating all duals identically wastes resources on the automatically exempt majority while under-serving the expansion dual minority facing real documentation barriers.

The segmentation requires data integration D-SNPs may not currently have. Medicare eligibility files show whether someone qualified based on age or disability but not whether they receive SSI. Medicaid eligibility files show entry pathway but not current exemption status. Social Security Administration has disability determination data but doesn't share automatically with D-SNPs.

Building the stratification system means requesting SSI status data from states, obtaining Medicare entitlement basis codes from CMS, creating flags in care management systems identifying expansion versus traditional eligibility, and developing assessment protocols for exemption likelihood. This infrastructure must be operational before work requirements begin because once implementation starts, reactive categorization is too late.

The business justification is straightforward. Category one members (the vast majority) need no additional work requirement support, conserving resources. Category two members (small minority) need one-time exemption documentation, not ongoing verification support. Category three and four members require flexibility pending state decisions and individual circumstances. Resource allocation matches actual risk rather than treating all duals identically.

For D-SNPs serving primarily traditional duals, work requirement exposure is minimal. A plan with 10,000 dual members might have only 200-500 expansion duals requiring support. For D-SNPs concentrating on younger disabled populations in expansion states, the proportion could reach 10-15 percent but rarely higher. Most D-SNPs face concentrated but manageable challenges, not existential disruption.

Article 4A detailed state redetermination scheduling choices affecting the 18.5 million expansion adults facing semi-annual cycles. For the subset who are expansion duals, add the Medicare renewal timing creating triple coordination challenge. While states control Medicaid redetermination timing, Medicare operates on federal schedules that cannot align. Someone might face Medicare renewal in March, Medicaid redetermination in April and October, and monthly work verification throughout. The stratification system must track all three cycles for each affected member.

Exemption Documentation as Care Coordination Function

Redefining the Care Coordinator Role

For expansion duals likely qualifying for medical exemptions, documentation becomes core D-SNP responsibility. This isn't traditional care coordination. It's legal advocacy requiring different skills and relationships.

The process starts with functional assessment. The care coordinator evaluating member needs must also evaluate work capacity. Someone with diabetes and hypertension may manage conditions well with medication and maintain full-time employment. Someone with identical diagnoses but cognitive impairment from stroke history cannot work consistently. The medical conditions alone don't determine exemption. The functional limitations do.

Article 4B examined special populations facing exemption barriers: serious mental illness, intellectual and developmental disabilities, substance use disorders. All these populations are represented in dual eligible

enrollment requiring intensive support. Someone with bipolar disorder qualified for Medicare disability during acute phase but currently stable on medication faces Article 4B's episodic condition challenge plus the dual eligible complexity of potentially needing separate Medicaid exemption despite Medicare disability status.



Provider Partnership Infrastructure

Strategic insight: Exemption success depends on provider engagement. Without simple physician documentation pathways, valid exemptions go undocumented and members lose coverage inappropriately.

D-SNPs must train care coordinators on disability determination standards. What constitutes medical frailty under state definitions? How do state systems define inability to work? What documentation proves functional limitations? How do mental health conditions qualify? What role does pain, fatigue, or episodic illness play? Care coordinators need frameworks for translating clinical observations into exemption applications.

The provider relationship becomes crucial. Primary care physicians, psychiatrists, and specialists hold documentation power through medical records, functional assessments, and attestation letters. D-SNPs must create provider-friendly processes. Simple templates physicians can complete during clinical encounters. Integration with electronic health records so documentation happens during normal workflow. Clear compensation mechanisms acknowledging unfunded administrative work.

Some D-SNPs will create medical director exemption support. The plan's physician leadership reviews complex cases, consults with treating physicians, and provides medical expertise on exemption applications. This physician-to-physician consultation helps community providers understand what information states need and how to document functional limitations supporting exemption.

The appeals infrastructure becomes essential. Initial exemption denials will happen. Medical evidence is ambiguous. State reviewers apply strict standards. Members have incomplete documentation. D-SNPs must prepare for systematic appeals including tracking denial reasons, gathering additional documentation, filing timely appeals, maintaining member coverage during appeals through presumptive eligibility, and monitoring appeal outcomes to improve initial application quality.

The cost is substantial but scaled to actual exposure. For D-SNP with 10,000 dual members where 300 are expansion duals and 150 need exemption support, assume 20 hours per exemption initially (assessment, documentation gathering, application preparation, provider coordination) at \$60 per hour fully loaded cost. Initial exemption documentation costs \$180,000. Annual renewals require less time but ongoing expense. The alternative is members lose coverage unnecessarily, generating even higher costs through emergency utilization and churn.

For D-SNPs with minimal expansion dual enrollment (the vast majority of plans), costs are negligible. For specialized D-SNPs serving younger disabled populations in expansion states, costs can reach \$500,000-\$2 million annually depending on scale. **The concentration matters:** most plans face minimal costs because their members are traditional duals (auto-exempt), while specific plans in expansion states serving younger disabled populations face intensive costs. System-wide across all D-SNPs, national costs likely total \$300-500 million annually for the expansion dual subset, concentrated in specific markets and specific plans rather than distributed across all 13.7 million duals.

Communicating Work Requirements to Cognitively Impaired Populations

Article 6A noted that 48 percent of duals have cognitive or mental health impairments. Traditional administrative notices assume reading comprehension, executive function, and systems navigation capacity many duals lack. Communication strategies must acknowledge these barriers.

Cognitive accessibility principles start with readability. Most state notices operate at twelfth grade reading level or higher. Dual eligibles need sixth grade maximum. Sentences should be short, vocabulary simple, concepts concrete. Legal language and bureaucratic jargon must disappear. "You must verify work activity or obtain exemption documentation to maintain Medicaid eligibility" becomes "Work 80 hours monthly OR get exemption form OR lose Medicaid."

Visual communication helps when text fails. Pictographs showing someone working at computer paired with "80 hours monthly" or someone in hospital bed paired with "exemption" convey requirements to people with limited English proficiency or cognitive limitations. Decision trees with branching logic guide someone through: "Do you work? YES, report hours. NO, continue. Do you have disability or illness? YES, file exemption. NO, find job or school."

Multiple communication modalities reach people with different barriers. Text messages for those comfortable with phones: "Your Medicaid work requirement is due in 10 days. Call 555-0123 for help." Outbound calls using interactive voice response systems offering options to speak with navigator. Home visits from community health workers for highest-risk members. Posters and handouts at dialysis centers, behavioral health clinics, primary care offices where duals receive services.

Language access becomes critical. Twenty-three percent of duals speak Spanish as primary language, 4 percent Chinese, 2 percent Russian, 1.5 percent Vietnamese. Article 2C covered language access principles broadly. For duals, these principles must apply with additional complexity. Someone with limited English proficiency AND cognitive impairment AND serious mental illness needs communications in their language at their comprehension level delivered through channels they can access during periods when illness allows engagement.

Legal representative authorization creates additional complexity. Many duals have guardians, conservators, or powers of attorney managing healthcare decisions. Communications must go to authorized representatives. Systems must track representative relationships. Care coordinators must know who holds decision-making authority for each member. Sending work requirement notices to cognitively impaired members without copying legal representatives guarantees non-compliance through inability to respond.

Video explanations with captions in multiple languages help people who learn better visually or auditorily than through text. Simple animations showing verification process step by step, exemption application procedures, where to get help. Available on plan websites, viewable on smartphones, playable in clinic waiting rooms.

California, Texas, and New York: Three Approaches to Dual Eligible Work Requirements

Implementation will vary dramatically based on state choices. Three largest dual eligible populations illustrate the spectrum.

California: 1.4 Million Duals, Presumed Automatic Exemptions

California's 1.4 million dual eligibles include approximately 850,000 enrolled in D-SNPs. The critical distinction: the vast majority are traditional duals automatically exempt through SSI (approximately 40 percent) or age over 60 (most of the remainder). The expansion dual population likely numbers 40,000-70,000 statewide, concentrated in younger disabled populations.

California's history suggests maximum use of automatic exemptions. Prior Medicaid policy choices emphasized beneficiary protection over program integrity verification. California's response to Medicaid unwinding prioritized continuity over redetermination rigor.

Article 6B: What D-SNPs and States must do



For expansion duals, California will likely create automatic work requirement exemption for anyone receiving Medicare based on disability. The SSA disability determination will transfer directly to Medicaid systems. No separate application required. No additional medical documentation demanded. Someone qualified disabled enough for Medicare is disabled enough for Medicaid exemption automatically.

County-level Medicaid administration complicates state coordination. California operates county-administered Medicaid with 58 separate systems. Uniform state policy must implement across disparate county infrastructures with varying technology capacity. But the scale of affected population is manageable. If 40,000-70,000 expansion duals statewide distribute across 58 counties, that's roughly 700-1,200 per county on average. Large counties like Los Angeles may have several thousand. Small counties may have dozens. Los Angeles County with 400,000 dual eligibles operates differently than Alpine County with under 100.

The D-SNP market is robust with multiple FIDE SNPs operating. Molina, Health Net, and Anthem offer fully integrated plans where work requirement Medicaid termination forces complete disenrollment from Medicare Advantage. These plans face existential business model threats unless automatic exemptions protect their members.

Expected policy clarity timeline: March 2026. California moves deliberately through stakeholder engagement processes. State officials will convene advisory groups, hold public comment periods, negotiate with plans and advocates. Final policy likely emerges late in preparation timeline creating compressed implementation window for D-SNPs.

Texas: 890,000 Duals, Verify Everything Approach

Texas's 890,000 dual eligibles include approximately 420,000 in D-SNPs, but the vast majority are traditional duals automatically exempt through SSI or age. Texas delayed Medicaid expansion until 2023. The expansion dual population is minimal because people haven't had time to enter expansion, develop qualifying disability, and complete the 29-month SSDI/Medicare waiting process. The affected expansion dual population likely numbers fewer than 10,000 statewide.

Despite the small scale, state implementation will likely require separate exemption determinations for expansion duals despite Medicare disability. Texas's approach to SNAP work requirements, Medicaid unwinding, and benefit program administration **consistently emphasizes verification over presumptive approval.**

Someone with Medicare disability who entered Medicaid through expansion must apply separately for Medicaid work requirement exemption. Current medical evidence from treating physicians required. Functional capacity assessment completed. SSA disability determination acknowledged but not automatically accepted as sufficient. The state will verify everything, trust nothing automatically.

The D-SNP market concentrates around UnitedHealthcare and Molina. These two plans dominate with smaller regional plans serving specific geographies. For D-SNPs, Texas represents administrative complexity disproportionate to affected population size. The burden per expansion dual member is high even though total expansion dual membership is small.

Expected policy timeline: January 2026. Texas typically moves faster than other large states on program integrity initiatives. Early adopter posture means policy finalization before most states decide approaches. D-SNPs operating in Texas must prepare first, building systems that may not match other states' requirements when those policies emerge later.

New York: 850,000 Duals, Split Determination Possible

New York's 850,000 dual eligibles include approximately 490,000 in D-SNPs. State policy will likely split between SSI recipients (automatic exemption) and SSDI-only beneficiaries (separate determination possible). The distinction matters because SSI requires more stringent disability standards while SSDI has broader qualifying conditions.

The managed care landscape is complex with regional variation. New York City operates different managed care systems than upstate counties. Different plans dominate different regions. Implementation uniformity across the state will be challenging.

Strong advocacy community will push for broad automatic exemptions. New York has active Medicaid beneficiary advocacy organizations with political influence. Pressure for beneficiary-protective policies will be substantial. Countervailing pressure from legislative fiscal conservatives will push for verification requirements.

Expected approach: automatic exemptions for those where documentation is straightforward, real-time eligibility data feeds to D-SNPs enabling proactive intervention, but potential separate determination for ambiguous cases. Timeline: protracted negotiation likely means final policy summer 2026, creating very compressed D-SNP implementation timeline.

Multi-State D-SNP Implications

Plans operating across all three states face impossible complexity. Build three completely different systems? Build one flexible system accommodating all approaches? Wait for the most restrictive state's policy then apply everywhere? Each choice has costs and risks.

Centene operates D-SNPs in all three states serving over 800,000 combined dual eligibles. UnitedHealthcare covers approximately 650,000 across the three. Humana roughly 400,000. These plans must invest millions in system development applicable to one state that may not work in another. The strategic choice between state-specific versus flexible-national approaches determines whether implementation costs are manageable or crushing.

Strategic insight across all three states: Policy decisions in California, Texas, and New York directly affect perhaps 85,000-140,000 expansion duals maximum. Most D-SNP enrollment in these states consists of traditional duals with automatic exemptions and minimal operational disruption. Specialized D-SNPs serving younger disabled populations in expansion pathways face concentrated challenges. Market segmentation matters more than aggregate dual eligible counts suggest. Multi-state operators need flexible systems but won't face universal disruption across their entire dual eligible portfolio.

D-SNP Integration Models and Differential Impact

Not all D-SNPs face equal disruption from work requirements. Integration type determines how severely Medicaid termination affects plan operations and member care.

Coordination-Only D-SNPs (60.6 Percent of Plans, Approximately 3.4 Million Enrollees)

These plans coordinate Medicare and Medicaid benefits but different organizations hold the contracts. Medicare Advantage from one entity, Medicaid from another. For the small subset of expansion duals in these plans, work requirements create coordination challenges but not contractual crises.

When expansion dual members lose Medicaid, plans lose care coordination responsibilities and some supplemental benefit funding. But Medicare Advantage contract continues. Member remains enrolled. Clinical relationships persist. The disruption is operational, not existential.

Article 6B: What D-SNPs and States must do



Most coordination-only D-SNPs serve primarily traditional duals with automatic exemptions. Work requirement impact touches only the expansion dual minority within their enrollment. These plans face manageable adaptation rather than fundamental business model threats.

Highly Integrated D-SNPs - HIDE (29.8 Percent of Plans, Approximately 1.7 Million Enrollees)

Same parent organization holds both Medicare and Medicaid contracts with tighter operational integration. Shared infrastructure, coordinated care teams, unified member experience. Revenue streams from both programs support integrated operations.

For expansion dual members, Medicaid termination creates more disruption than coordination-only models. Care models assume both revenue streams. Integrated teams must adapt when Medicaid funding disappears mid-care episode. Systems built for unified member experience must accommodate bifurcated coverage.

But again, most HIDE SNP enrollment consists of traditional duals with minimal work requirement exposure. The operational challenge concentrates in plans serving higher proportions of younger disabled populations who entered through expansion pathways.

Fully Integrated D-SNPs - FIDE (8 Percent of Plans, Approximately 450,000 Enrollees)

FIDE SNPs face the most severe impact. They must cover comprehensive long-term services and supports, behavioral health, and home health with exclusively aligned enrollment. Members cannot enroll in FIDE SNP without the aligned Medicaid managed care plan. When work requirements terminate Medicaid coverage, members must disenroll from the FIDE SNP entirely.

Loss of both revenue streams simultaneously threatens the business model. FIDE SNPs invested in integrated infrastructure assuming enrollment stability. Work requirement-driven churn makes the full integration model financially unsustainable unless automatic exemptions protect expansion dual members.

Only 12 states offer FIDE SNPs, limiting geographic exposure. But in those states, FIDE SNPs serving younger disabled populations face existential challenges. Unless California, New York, and other FIDE-heavy states provide automatic Medicare disability exemptions, the integrated care model dissolves for expansion duals.

Strategic insight: Work requirements don't threaten all D-SNPs equally. Coordination-only plans serving traditional duals face minimal disruption. FIDE SNPs serving expansion duals in restrictive states face potential market exit. Impact varies dramatically by integration model, member mix, and state policy choices.

Technology Integration: Building Verification Facilitation

The Trusted Intermediary Model

For expansion duals who don't qualify for exemptions, work verification becomes routine administrative task. D-SNPs can serve as trusted intermediaries reducing member burden while ensuring compliance.

The employer partnership model works for members with stable W-2 employment. D-SNP identifies member's employer, establishes relationship with HR department, negotiates standardized verification letter or automated reporting, and facilitates monthly or quarterly transmission to state systems. Member authorizes D-SNP to receive employment verification. Employer sends single consolidated report to D-SNP covering all employees enrolled in the plan. D-SNP submits verified data to state on behalf of members.

This reduces employer burden by consolidating requests, reduces member burden by eliminating individual submission requirements, increases verification accuracy through professional handling, and ensures timely

submission preventing deadline misses. Large employers with multiple D-SNP members benefit from single point of contact. Small employers appreciate simplified process.



Article 4C outlined multi-stakeholder technology requirements for work verification systems. D-SNPs must integrate with all those systems while managing Medicare data flows simultaneously. State eligibility systems, employer payroll processors, community-based organizations providing verification support, member-facing applications all require different integration approaches.

Build Versus Buy Decisions

Strategic insight: Custom technology development takes 12-18 months. The December 2026 deadline requires vendor partnerships or rapid procurement. No time for building from scratch.

D-SNPs face build versus buy decisions on verification technology. Building custom solutions offers perfect fit to specific needs but requires 12-18 months development time plus testing. The December 2026 deadline makes custom development impossible unless started immediately with substantial risk of state policy changes invalidating architectural choices.

Buying existing vendor solutions offers faster deployment but potential misfit to state-specific requirements. GroundGame.Health, Unite Us, findhelp, and others offer social determinants platforms that could extend to work verification. Integration with existing D-SNP care management systems varies by vendor. Implementation timelines span 4-6 months for proven products but customization for work requirements adds complexity.

Partnership approaches leverage existing infrastructure. Payroll processors like ADP, Paychex, and Gusto already transmit employment data for various purposes. Extending their systems to include Medicaid work verification reduces D-SNP development burden. But negotiating partnerships, establishing data sharing agreements, building security protections takes time. The 14-month implementation window allows for either vendor procurement or partnership development but not both sequentially. D-SNPs must choose paths quickly.

The cost calculations favor buying or partnering over building. Custom development costs \$3-5 million for mid-sized D-SNP. Vendor solutions cost \$400-600k annually. Partnerships might involve revenue sharing or per-transaction fees. Build costs are sunk immediately. Buy costs spread over time. Partnership costs scale with usage. Financial structure matters for plans with constrained capital budgets.

Technology must accommodate state variation. Texas requires monthly verification. California might require quarterly. New York might create presumptive eligibility meaning missed deadlines don't immediately terminate coverage. The system must configure differently for each state, each member based on state residence, each verification cycle based on state policy. Hard-coding requirements guarantees failure when states change policies or members move between states.

SDOH Platform Partnerships: Leveraging Existing Infrastructure

Strategic insight: Social determinants of health platforms already connect care coordinators, community resources, and health systems. Extending these platforms for work requirement coordination leverages existing relationships and infrastructure rather than building parallel systems.

D-SNPs already partner with SDOH platforms for resource referrals, care coordination, and social needs screening. UniteUs, GroundGame.Health, and similar platforms maintain networks of community-based organizations, track member interactions across multiple touchpoints, and provide care coordinators with visibility into social support services. Work requirement coordination fits naturally into this existing infrastructure.



The SDOH platform advantage is established workflows. Care coordinators already use these systems daily for housing referrals, food assistance, transportation coordination. Adding work verification and exemption support to familiar interfaces reduces training burden and increases adoption. Members already interact with community organizations through these platforms. Extending functionality to include work requirement navigation maintains continuity rather than introducing entirely new systems.

GroundGame.Health specifically designed its platform for Medicaid managed care organization use cases. The system already handles member consent management, multi-stakeholder coordination, outcome tracking, and state reporting requirements similar to what work verification demands. Extending the platform to capture employment verification, exemption documentation status, and compliance tracking requires configuration rather than fundamental rebuild. D-SNPs using GroundGame.Health for existing SDOH work can expand functionality incrementally.

UniteUs operates the largest coordinated care network nationally, connecting health systems, payers, government agencies, and community organizations. The platform's strength is cross-organizational workflow management. For work requirements, this means facilitating connections between D-SNPs, employers, state eligibility systems, and community navigators who support members with documentation. The network effect matters because employers and community organizations only want to learn one system, not separate platforms for each health plan.

The partnership model allows D-SNPs to implement faster than custom development. SDOH platforms have existing contracts with many D-SNPs, reducing procurement friction. Security and compliance frameworks already address HIPAA and state privacy requirements. Integration with D-SNP care management systems exists through current SDOH referral workflows. Extending these integrations for work verification requires less technical lift than building new connections from scratch.

Cost structures favor SDOH platform partnerships for mid-sized D-SNPs. Annual platform costs typically run \$300-500k for D-SNPs with 15,000-30,000 members, covering SDOH coordination broadly not just work requirements. Adding work verification functionality might increase costs 20-30 percent (\$60-150k incremental) rather than requiring separate \$400-600k verification-only system purchases. For D-SNPs already using SDOH platforms, incremental expansion is the most cost-effective path.

The limitation is state-specific requirement accommodation. SDOH platforms built for national markets must configure differently for each state's verification frequency, exemption documentation standards, and data exchange specifications. Platforms with experience in multiple state Medicaid systems adapt more easily. Newer vendors might struggle with variation.

D-SNPs should evaluate existing SDOH partnerships first before procuring separate work verification systems. If current SDOH platform can extend functionality and vendors commit to work requirement feature development, that path offers fastest implementation with lowest disruption to care coordinator workflows. If current SDOH partner cannot or will not extend platforms appropriately, D-SNPs must choose between switching SDOH platforms entirely or maintaining separate work verification systems alongside existing SDOH tools.

What CMS Requires from D-SNPs on Work Requirement Support

Current Requirements Extended

D-SNPs already operate under Centers for Medicare and Medicaid Services requirements distinct from standard Medicare Advantage plans. Unified grievance and appeals processes spanning both Medicare and Medicaid. Care coordination integrating services across both programs. Model of Care documentation demonstrating integration approach. Medicare Star Ratings measuring quality with specific D-SNP measures.

Work requirements will likely trigger new CMS requirements or guidance on existing requirements. Can work requirement navigation become a supplemental benefit funded through Medicare Advantage bids? Supplemental benefits must be "primarily health-related" under CMS rules. Navigation preventing coverage loss maintains medication access, enables care continuity, prevents emergency utilization. The health relationship is clear but whether CMS will approve supplemental benefit funding remains uncertain.

Care coordination protocols will likely require explicit work requirement support documentation. D-SNPs submit Model of Care documents to CMS describing how care coordination operates. Work requirement implementation may require Model of Care amendments showing exemption support processes, verification facilitation approaches, gap period interventions. Plans must update Models of Care demonstrating how work requirements integrate into care coordination rather than operating as separate administrative function.

Member communications requirements will intensify. CMS requires accessible communications in prevalent languages. Work requirement communications must meet these standards. Cognitive accessibility for populations with intellectual disabilities. Plain language at appropriate reading levels. Visual aids for low-literacy members. Multiple modalities for members with communication barriers. CMS will scrutinize whether D-SNPs adequately inform vulnerable members about requirements and available support.

Quality Measurement Implications

Medicare STAR Ratings assume continuous enrollment for measurement. Breast cancer screening rates, diabetes care measures, medication adherence all calculate based on enrollment stability. Work requirement churn artificially depresses these measures for D-SNPs serving expansion duals regardless of care quality.

CMS must either risk-adjust STAR Ratings for work requirement volatility or create separate reporting standards for D-SNPs with high expansion dual enrollment. Risk adjustment maintains single quality standard while acknowledging structural barriers. Separate reporting acknowledges different operating environments but creates two-tier quality expectations.

Alternatively, CMS could create new quality measures specific to work requirement implementation. Coverage retention rates among expansion duals. Exemption application success rates. Time from coverage loss to reinstatement. Member satisfaction with work requirement support. These measures assess D-SNP effectiveness at mitigating work requirement impacts rather than clinical quality.

The measurement approach determines D-SNP incentives. Risk-adjusted single standards maintain pressure for quality regardless of population characteristics. Separate standards risk creating lower expectations for plans serving vulnerable populations. New work requirement-specific measures add reporting burden but provide transparency on implementation effectiveness.

Contract Requirement Conflicts

Medicare Advantage contracts specify D-SNP obligations to CMS. Medicaid managed care contracts specify D-SNP obligations to states. Misalignment creates compliance challenges. CMS might require presumptive eligibility during exemption processing. States might prohibit benefits during pending applications. Which requirement controls?

Federal preemption generally allows Medicare requirements to supersede state Medicaid rules when conflict exists. But work requirements are federal law implemented through state systems. Whether CMS can require D-SNP actions contradicting state Medicaid policies is legally ambiguous. D-SNPs need clarity on which obligations control when conflicts arise.

The practical reality is D-SNPs will try to satisfy both CMS and state requirements simultaneously even when inconsistent. This means building more elaborate systems accommodating both sets of rules, maintaining separate processes for Medicare versus Medicaid reporting, and documenting compliance with sometimes contradictory standards. The administrative cost multiplies.

Liability Exposure When D-SNPs Facilitate Verification

D-SNPs serving as trusted intermediaries for work verification create potential legal liability. If a D-SNP submits employment verification on a member's behalf and the information proves inaccurate, who bears responsibility?

Member commits fraud by inflating hours worked. D-SNP facilitates submission based on employer-provided data. State later audits and discovers false reporting. Is the D-SNP liable for facilitating fraudulent submission? Did the D-SNP have duty to verify employer data independently? Or did the D-SNP act in good faith as mere transmitter of employer-certified information?

Employer provides inaccurate data unintentionally. Payroll error overstates hours. D-SNP submits employer-certified information believing it accurate. Member maintains eligibility based on false data. State discovers error and seeks recovery. Can the state pursue the D-SNP for inaccurate submission even though D-SNP relied on employer attestation?

The good faith intermediary question is crucial. If D-SNPs are mere conduits transmitting employer-certified data, liability should rest with member (if fraudulent) or employer (if error). But if D-SNPs are expected to verify data accuracy beyond employer attestation, liability exposure increases substantially and trusted intermediary model becomes unsustainable.

States must provide clear safe harbor protections. D-SNPs acting as verification intermediaries based on employer-certified data should face no liability for submission accuracy beyond confirming employer attestation exists. Without safe harbor, D-SNPs will avoid intermediary roles forcing members to navigate verification directly.

The compliance infrastructure D-SNPs must build includes audit trails showing verification data source, employer attestation documentation, member authorization for D-SNP submission, submission timestamps proving timely filing, and state receipt confirmation. This documentation protects D-SNPs if disputes arise about verification accuracy or timeliness.

Member consent and authorization documentation becomes critical. D-SNPs cannot access employment records or submit verification on member behalf without explicit authorization. HIPAA doesn't cover employment data. State privacy laws may restrict D-SNP access. Clear consent processes with documented member agreement to D-SNP intermediary role provides legal foundation.

State Decision Timelines: Critical Path for D-SNP Planning

D-SNP preparation depends on state policy clarity. The state decision timeline determines whether D-SNPs have adequate time to build correct systems or must guess state approaches risking substantial rework.

January 2026: Month 2, Initial Policy Framework

By January 2026, states must clarify foundational questions. Does Medicare disability determination create automatic Medicaid work requirement exemption? Or does the state require separate determination despite Medicare disability? This single choice determines whether the few hundred thousand expansion duals face documentation burden or receive automatic protection.

States must also define whether Medicare Savings Program enrollees face work requirements. Partial benefit duals receive premium assistance but limited other benefits. Are they subject to work requirements as

Medicaid beneficiaries? Or exempt because MSP is distinct from comprehensive Medicaid? The answer determines whether 4.7 million people face requirements or exemptions.

Without these January decisions, D-SNPs cannot build correct population stratification systems. If a D-SNP assumes automatic exemptions and builds systems accordingly, then a state announces separate determination requirements in June, the entire stratification approach requires rebuilding under severe time pressure.

March 2026: Month 4, Exemption Process Details

By March 2026, states must publish exemption application forms and documentation standards. What medical evidence proves medical frailty? Which healthcare providers can complete exemption documentation? How do mental health conditions qualify? What functional assessments are required? These details determine D-SNP exemption support processes.

States must also specify verification frequency. Monthly work reporting? Quarterly? Semi-annual aligned with redetermination? The frequency determines technology requirements, care coordinator workload, and member burden. D-SNPs building monthly verification systems cannot easily adapt if states announce quarterly requirements late in planning cycle.

States must finalize data sharing capabilities and API specifications. Will states provide real-time eligibility feeds to D-SNPs? Can D-SNPs query eligibility status programmatically? What security requirements govern data exchange? Without technical specifications, D-SNPs cannot build integration connections. Without data sharing agreements, D-SNPs cannot receive information needed for proactive member support.

Article 4A's state coordination challenges apply but intensify for duals. States coordinating only Medicaid redetermination face complex scheduling. States coordinating Medicaid redetermination, work verification, AND Medicare processes face impossible synchronization.

June 2026: Month 7, Data Integration Implementation

By June 2026, states must execute data sharing agreements with D-SNPs. Legal documents specifying what information states will provide, update frequency, security protections, permitted uses. Without executed agreements, D-SNPs cannot access state data even if technical systems exist.

States must provide testing environments for technology integration. D-SNPs need to validate that APIs work correctly, data formats match specifications, error handling functions properly. Production deployment without thorough testing guarantees failures affecting member coverage.

States must train eligibility staff on dual eligible complexities. State workers processing exemption applications must understand Medicare-Medicaid relationships, D-SNP care coordination models, why dual eligibles face particular barriers. Inadequately trained staff will deny valid exemptions or demand inappropriate documentation.

September 2026: Month 10, Member-Facing Systems Launch

By September 2026, states must complete provider portals for exemption documentation. Physicians need simple interfaces for submitting functional assessments. Without provider-friendly systems, valid exemptions go undocumented because completing paper forms during clinical encounters is impossible.

States must launch member communication campaigns explaining work requirements, exemption processes, where to get help. Communications must reach vulnerable populations in accessible formats. Campaigns starting in November leave inadequate time for members to understand requirements and obtain exemptions before December implementation.

States must activate presumptive eligibility policies for members with pending exemption applications. Coverage continuing during processing prevents unnecessary gaps. Policies activated at implementation rather than before create immediate coverage losses for anyone whose application isn't decided by December 1.

Reality Check: Most States Won't Meet These Deadlines

The timeline above represents best-case scenario assuming state commitment and adequate resources. Most states will miss deadlines. Policy decisions will come late. Data sharing agreements will execute slowly. Testing environments will arrive incomplete. Provider systems will launch with problems. Member communications will be rushed.

D-SNPs must plan for delayed state decisions. This means building flexible systems accommodating uncertainty, developing contingency plans for multiple state approaches, maintaining capacity to pivot when policies finally clarify, and accepting that some implementation investment will be stranded cost when state decisions differ from assumptions.

The consequences of state delays fall hardest on dual eligibles. Late policy clarity means rushed implementation. Rushed implementation means more errors, more inappropriate coverage losses, more members falling through cracks. The people most vulnerable to policy complexity suffer most from inadequate preparation time.

Who Pays for What: The Concentrated Cost Reality

Understanding the Market Segmentation

Strategic insight: Implementation costs are concentrated, not distributed. Most D-SNPs face minimal costs because their members are traditional duals (automatically exempt). Specific D-SNPs serving significant expansion dual populations in expansion states face intensive costs.

The national dual eligible population of 13.7 million creates a misleading impression of uniform impact. The vast majority are traditional duals who entered through SSI or are over 60, facing automatic exemption from work requirements. The expansion dual population nationally is estimated at few hundred thousand maximum, concentrated in specific geographic markets and specific D-SNP products.

D-SNP Direct Costs: Scaled to Actual Exposure

For the majority of D-SNPs, implementation costs are negligible. A plan serving 50,000 traditional duals needs minimal system changes. Risk stratification identifies nearly all members as automatically exempt. No exemption documentation support is needed. No verification facilitation required. Perhaps \$100,000-\$200,000 in initial assessment and communication costs, plus minimal ongoing expenses.

For D-SNPs serving significant expansion dual populations, costs are substantial. Consider a specialized D-SNP in California or New York with 20,000 dual members where 2,000 (10 percent) are expansion duals. One-time expenses include risk stratification data integration costing \$300,000-\$500,000 to identify expansion versus traditional duals accurately. Technology for exemption tracking and care coordination costs \$800,000-\$1.2 million. Care coordinator training requires \$150,000-\$250,000. Provider engagement infrastructure costs \$100,000-\$200,000.

Total one-time implementation: \$1.35-2.15 million for this specialized plan serving significant expansion dual population.

Annual ongoing costs for the same plan: exemption documentation support for 1,000 expansion duals requiring exemptions (500 in first year, 500 renewals annually) at 20 hours each and \$60 per hour equals \$1.2 million. Care coordinator time dedicated to expansion dual support costs \$400,000-\$600,000. Technology

operations cost \$150,000-\$250,000. Appeals support runs \$100,000-\$150,000. Gap period uncompensated care averages \$200,000-\$400,000.

Total annual ongoing: \$2.05-2.6 million. On PMPM basis for expansion duals only, this equals \$85-\$108 PMPM. But spread across all 20,000 dual members (most of whom need no support), this averages \$8.54-\$10.83 PMPM.

The market concentration matters enormously. Centene serves over 2 million dual eligibles, but the expansion dual subset is estimated at 80,000-120,000 concentrated in specific states and specific product lines. For Centene, total implementation costs are likely \$30-50 million one-time plus \$15-25 million annually, not the hundreds of millions implied by treating all duals identically.

System-wide across all D-SNPs nationally, implementation costs for expansion dual coordination total approximately \$300-500 million, not \$5-8 billion. The costs are real and substantial for plans serving expansion duals, but they're concentrated rather than distributed across the entire dual eligible market.

State Administrative Costs: Geographic Concentration

State implementation costs vary wildly by population size and existing system sophistication. Eligibility system modifications range from \$10 million for small states with modern systems to \$50 million for large states with legacy infrastructure. Staff hiring and training costs \$5-15 million depending on case-load size and whether states rely on existing workers or hire new positions. Data sharing infrastructure investments run \$2-5 million for API development, security implementation, testing environments.

Provider and employer engagement programs cost \$1-3 million for outreach, education, partnership development. Communication campaigns targeting vulnerable populations require \$3-10 million for materials development in multiple languages, advertising, community outreach. Total state implementation costs range from \$21 million for small states to \$83 million for large states with complex Medicaid programs.

For the ten largest states by dual eligible population, total implementation costs likely exceed \$600 million. Add the remaining 40 states and total state spending approaches \$1-1.5 billion. Federal implementation appropriation under OB3 provides \$400 million total across all states, averaging \$8 million per state. This funding covers less than half of actual state costs even under optimistic projections.

States must use general revenue or Medicaid administrative funding to cover gaps. Federal Financial Participation provides 50 percent federal match on administrative expenses for most states, though enhanced match rates apply in some circumstances. This means states spending \$80 million on implementation receive \$40 million federal reimbursement but must fund \$40 million from state budgets.

Wealthy states like California, New York, and Massachusetts can afford robust implementation systems. They'll build sophisticated technology, hire adequate staff, and provide intensive member support. Poor states like Mississippi, Alabama, and West Virginia will build minimal systems, strain existing staff, and provide limited support. The implementation quality divergence creates dual eligibles in different states experiencing fundamentally different work requirement processes.

Federal Costs

Beyond state appropriations, federal costs include CMS oversight and technical assistance estimated at \$50 million annually. Social Security Administration data sharing infrastructure requiring systems connecting SSA disability records to state Medicaid systems costs approximately \$25 million one-time. Federal matching payments for state administrative expenses range from \$500 million to \$1 billion depending on state spending and match rates.

Most significantly, Medicare Advantage payment increases to D-SNPs for work requirement support costs are unknown but potentially substantial. If CMS allows supplemental benefit funding for verification

navigation, this increases Medicare Advantage bids. If Star Rating risk adjustment for work requirement churn increases quality bonus payments, this raises Medicare costs. Increased acute care utilization when Medicaid wraparound disappears drives Medicare spending higher. Conservative estimates suggest \$1-2 billion annual Medicare cost increases once work requirements reach steady state.

The Cost-Shifting Reality

D-SNPs spend \$6 PMPM on average to prevent coverage loss through exemption support and verification facilitation. Coverage loss costs approximately \$400 per member in churn expenses (disenrollment processing, re-enrollment, care disruption) plus \$800 in increased emergency utilization during gaps. Total cost per coverage loss episode averages \$1,200.

If work requirement support prevents coverage loss for 80 percent of at-risk members, the D-SNP spends \$72 annually (\$6 PMPM for 12 months) to avoid \$1,200 in churn costs. The return on investment is clear: every dollar spent on prevention saves \$16 in coverage loss costs. But D-SNPs must finance prevention upfront while bearing churn costs for the 20 percent who lose coverage despite support.

States save Medicaid expenditures when members lose coverage but face increased uncompensated care costs at state-funded hospitals and clinics. A member losing Medicaid still gets sick, still needs care, still shows up at emergency departments. The costs shift from Medicaid program budget to hospital budgets and state charity care appropriations. Total state spending may not decline despite Medicaid savings.

Medicare bears increased acute care costs when Medicaid wraparound disappears. Someone with diabetes and Medicaid loses transportation to dialysis, medication assistance, care coordination. They miss treatments, skip medications, present in crisis. Medicare pays for emergency admissions and ICU stays that prevented access would have avoided. Medicaid saves money while Medicare spends more.

Federal government pays twice: implementation grants to states plus increased Medicare Advantage costs from higher utilization and Star Rating adjustments. Total federal spending increases substantially despite Medicaid coverage reductions.

Strategic insight: System-wide implementation costs over five years (\$5-8 billion across all stakeholders) likely exceed federal Medicaid savings from coverage losses, particularly when counting Medicare cost increases.

This is why Article 1A's systems view matters. Optimizing Medicaid spending in isolation may increase total healthcare costs systemwide. Preventing coverage loss costs money upfront but saves money overall. Yet no single stakeholder captures the full savings from prevention, so each entity under-invests in prevention relative to social optimum.

Operational Scenarios: How It Actually Works

Theory is important. Practice is reality. How do these systems actually function for individual members?

Member **John** works full-time at retail store, qualifies for Medicaid expansion, later becomes dual eligible through disability. He's in Category Three: work verification required unless exemption obtained. D-SNP contacts John's employer establishing automated monthly reporting. Payroll system transmits hours worked directly to D-SNP verification portal. D-SNP bundles John's data with other employees at same store and submits consolidated verification to state system. State confirms receipt and compliance. John works, payroll processes, verification happens automatically. No action required from John monthly. Coverage continues smoothly.

Member **Sandra** loses her job in Month 4. Automated verification system detects failed employer transmission. Care coordinator reaches out to Sandra immediately. Assessment reveals she's actively job

searching and caring for elderly mother. Care coordinator helps Sandra document job search activities qualifying temporarily while also initiating caregiver exemption application based on mother's care needs.

Job search verification submitted buying time while caregiver exemption processes. Within 45 days, caregiver exemption approves. Sandra transitions from work verification to exempt status. Care coordinator schedules check-in at month 11 confirming mother's ongoing care needs support exemption renewal. Coverage maintains continuity despite employment change.

Member **Robert** faces more complex situation. His serious mental illness creates episodic work capacity. He qualified for Medicare disability three years ago. State requires separate Medicaid exemption despite Medicare determination. Care coordinator gathers mental health provider documentation, completes exemption application emphasizing episodic nature requiring exemption not work verification, and submits to state.

State denies exemption citing that Robert works sometimes. Care coordinator files appeal with additional documentation from psychiatrist explaining that episodic capacity doesn't mean consistent work ability. During appeal, state policy provides presumptive eligibility continuing Medicaid. D-SNP maintains care coordination throughout. Appeal succeeds after 60 days. Exemption approves retroactively. Robert's care never disrupted though process required intensive support.

Article 4B's episodic condition challenges apply exactly here. Robert's functional capacity varies with illness cycles. Documentation during stable periods looks different than during acute phases. The state reviewer not familiar with bipolar disorder patterns may misunderstand episodic incapacity. The D-SNP's role becomes education as much as documentation.

These operational scenarios show successful integration. They require systems working correctly, care coordinators trained properly, state policies designed thoughtfully, and coordination maintained continuously. Many implementations won't achieve this smoothness. The examples show what's possible with proper preparation.

Implementation Timeline: The 14-Month Sprint

December 2026 deadline is 14 months away. D-SNPs must accomplish substantial work in limited time.

Months 1 to 3: Assessment and planning. Analyze enrolled population identifying traditional versus expansion duals. Estimate members needing exemption support versus verification facilitation. Evaluate technology gaps between current systems and requirements. Engage state Medicaid agencies in preliminary discussions. Develop financial models projecting costs and rate negotiation needs. Secure board approval for implementation investments.

Months 4 to 6: Infrastructure building. Procure or build technology for verification facilitation and exemption tracking. Train care coordinators on exemption documentation processes and work requirement policies. Establish employer partnerships for verification automation. Negotiate data sharing agreements with states. Develop provider education materials and outreach plans.

Months 7 to 9: Pilot testing. Select subset of expansion duals for pilot intervention. Test exemption documentation workflows end-to-end. Validate verification facilitation technology with pilot employers. Identify operational issues requiring resolution. Refine protocols based on pilot learnings. Prepare for scale-up.

Months 10 to 12: Scaled implementation. Roll out exemption support to all category two members. Implement verification facilitation for category three members. Complete provider outreach ensuring network understands exemption documentation needs. Finalize state data exchange connections. Launch member communication campaigns explaining support available.

Months 13 to 14: Pre-launch final preparation. Complete remaining exemption applications. Confirm verification automation is operational. Train additional care coordinators if needed. Establish contingency plans for implementation issues. Prepare appeals infrastructure for expected denials. Ready gap period care bridge protocols.

This timeline assumes states provide policy clarity by Month 3 enabling D-SNPs to build correct systems. Delays in state decision-making compress D-SNP preparation time. Plans must balance starting infrastructure development despite uncertainty versus waiting for clarity risking inadequate preparation.

The Collaborative Imperative

D-SNPs serving expansion dual populations cannot succeed alone. State cooperation is essential. Automatic exemptions based on Medicare disability determination reduce burden exponentially for the affected subset. Real-time data sharing enables proactive intervention. Presumptive eligibility during processing prevents unnecessary gaps. Rate adjustments reflecting actual costs enable sustainable operations for specialized plans.

States cannot succeed without D-SNPs for the expansion dual population. Plans provide care coordination infrastructure states lack for this complex subset. They have relationships with members enabling outreach. Technology systems can facilitate verification submission. Clinical expertise supports exemption documentation. Partnership leverages existing assets rather than building parallel systems.

The organizations that will navigate this successfully will start now, invest appropriately scaled to their actual expansion dual exposure, collaborate actively with states, adapt continuously, and measure rigorously. Those that will struggle will treat all duals identically, over-invest in unnecessary infrastructure for automatically exempt populations, operate independently, resist segmentation, and hope uniform approaches work across diverse circumstances.

For expansion duals, the difference is whether integrated care survives work requirement implementation or becomes another casualty of policy complexity. For the vast majority of traditional duals, integrated care continues with minimal disruption. The next 14 months determine which outcome expansion duals experience.

Next in series: Article 7, "The Exemption Design Challenge: Protecting Vulnerability While Maintaining Integrity"

Previous in series: Article 6A, "The Dual Eligible Paradox: When Work Requirements Meet Medicare-Medicaid Coordination"

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