Medicare Advantage Final Rule: D-SNP and Dual Eligible Impacts

MAY 19, 2022

ATI Advisory

→ Background and Purpose

On April 29, 2022, CMS released its Medicare Advantage and Part D final rule: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs [CMS-4192-F].

A considerable portion of this Rule addresses dual-eligible special needs plans (D-SNPs) and the role of Medicare Advantage in better serving dual eligible beneficiaries. Program changes will be implemented between 2023 and 2025.

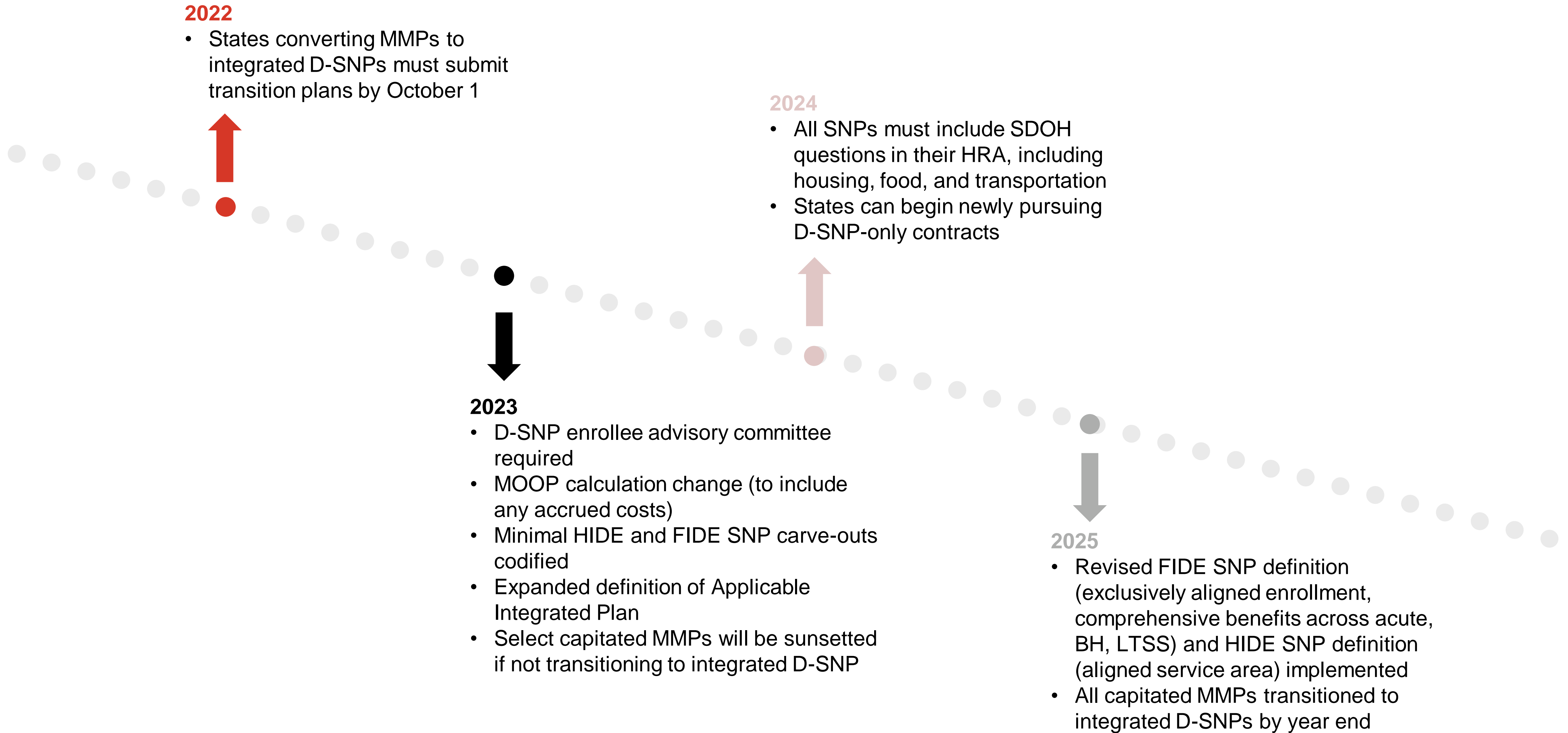
This deck is intended to provide stakeholders with a summary and insights into the key provisions impacting dual eligible beneficiaries. The Rule included provisions beyond those detailed in this summary deck.

Navigate directly to a section of this Rule summary:

- → Enrollee Advisory Committee
- → Health Risk Assessment
- → FIDE SNP Definition (enrollment, minimum scope of services)
- → FIDE/HIDE SNP Medicaid Design (carve-outs, service area)
- → Contract Structure for Exclusively Aligned Plans (and related state opportunities)
- → Applicable Integrate Plan Definition
- → MOOP Limits and Calculation
- → Converting MMP to Integrated D-SNPs

Term	Definition
CO-D-SNP	Coordination-only D-SNP, a designation for D-SNPs without financial and clinical Medicaid risk for long-term services and supports (LTSS) or behavioral health (BH)
HIDE SNP	Highly-Integrated D-SNP; D-SNP organization also has financial and clinical Medicaid risk for LTSS and/or BH in the state [definition changes detailed in this slide deck]
FIDE SNP	Fully-Integrated D-SNP; D-SNP legal entity also has Medicaid financial and clinical risk LTSS and BH in the state [definition changes detailed in this slide deck]
FAI, FAD, and MMP	The Financial Alignment Initiative (FAI) is demonstration authority within CMS that currently includes three types of Financial Alignment Demonstrations (FAD); capitated FAD is most common, which uses a three-way contract between a state, CMS, and a Medicare-Medicaid Health Plan (MMP)
HRA	All SNPs are required to conduct an initial and annual (re)assessment of each enrollee's physical, psychological, and functional needs via a comprehensive risk assessment tool, the Health Risk Assessment (HRA)
MOOP	Maximum Out-of-Pocket limit that all Medicare Advantage (MA) plans must establish, beyond which amount the MA plan pays 100 percent of service costs
Exclusively Aligned Enrollment	D-SNPs that only enroll individuals for whom they also have Medicaid LTSS and/or BH risk (e.g., via a companion Medicaid MCO contract)
Supplemental Benefits	Benefits available through Medicare Advantage that go above and beyond traditional Medicare Part A and B benefits; can include medical, non-medical, and social driver benefits within certain limits

SUMMARY TIMELINE OF D-SNP AND DUAL ELIGIBLE FINAL RULE PROVISIONS



→ Finalized as proposed:

- **Summary**
  Any MA organization offering a D-SNP must establish one or more enrollee advisory committees in each State to solicit direct input on enrollee experiences. The advisory committee must, at a minimum, solicit input on ways to improve access to covered services, coordination of services, and health equity among underserved populations. CMS provides D-SNPs with latitude to determine frequency, location, participant requiring, and other parameters.

- **Impact**
  This initiative will help plans understand their enrollees' community and the challenges they face as well as create a mechanism to get enrollee input on plan policy. States should consider the intersection and interaction of the D-SNP Enrollee Advisory Committee with other, Medicaid specific enrollee committees, and key outcomes they hope for the D-SNP Advisory Committee to achieve.

Rule Commentary Insights

→ Commenters offered strong support of this provision

→ CMS may require prescriptive requirements in the future, for example on committee race, age, and other demographic representation, and/or frequency, location, format, and other parameters of the committee; additionally, states are able to prescribe these requirements through the D-SNP SMAC

→ While committee meeting agendas and other materials will not be required to be public, CMS will update audit protocols to monitor D-SNP performance on this provision

→ Finalized with modification (italicized):

- **Summary**
  SNPs will be required to include questions in the HRA that address key social determinants of health: housing, food security, and transportation. *CMS will publish a list of screening instruments in sub-regulatory guidance, from which SNPs can choose their questions. HRA requirements will begin in 2024.*

- **Impact**
  SNPs will be required to incorporate the results of the HRAs in individualized care plans and consult with enrollees about their unmet care needs. Product and vendor opportunities to meet these needs may emerge as needs are quantified. Available data could inform supplemental benefit design as well.

  States should consider how to align related Medicaid HRA questions with the SNP HRA to minimize beneficiary and plan burden.

Rule Commentary Insights

→ CMS is aiming for flexibility by offering screening instruments SNPs can choose from without prescribing specific questions, but acknowledges the potential for additional and/or more specific HRA question topics in the future

→ CMS confirmed that community-based organizations or other subcontracted entities can conduct the HRA or portions of the HRA

→ CMS does not collect SNP HRA information currently (beyond the number of HRAs conducted) and will consider whether to do so in the future

→ Finalized as proposed:

- **Summary**
  All FIDE SNPs must have exclusively aligned enrollment with no partial dual beneficiaries allowed, beginning in 2025. Exclusively aligned enrollment occurs when a D-SNP only enrolls individuals for which it also has Medicaid risk for long-term services and supports and/or behavioral health. For FIDE SNPs, this risk is inclusive of a broader set of services, detailed on slide 8.

- **Impact**
  Select states currently do not have exclusively aligned enrollment and will need to split their programs (VA, PA, AZ) and/or convert FIDE SNPs to HIDE SNPs. All FIDE SNPs will now be required to comply with unified appeals and grievance standards, and states with FIDE SNPs will be able to pursue the single contract pathway due to exclusively aligned enrollment, described on slide 11. States should continue to explore plan design to maximize FIDE frailty payments that are commensurate with LTSS level of need.

Rule Commentary Insights

→ CMS acknowledged some FIDE SNPs will need to transition to HIDE SNP status in 2025, absent state Medicaid program change

→ CMS noted their continued effort to educate dual eligible individuals, including through State Health Insurance Assistance Programs (SHIPs), of the value of enrolling in a program with exclusively aligned enrollment

→ CMS will issue best practices, host events, and offer technical assistance to states trying to implement exclusively aligned enrollment

→ Finalized with modification (italicized):

- **Summary**
  At a minimum, FIDE SNPs must cover Medicaid home health, *medical supplies, equipment, and appliances*, and behavioral health beginning in 2025, in addition to current requirements to cover LTSS. FIDE SNPs must also cover all Medicaid primary care and acute care benefits including the Medicaid payment of Medicare cost sharing.

- **Impact**
  States with behavioral health carved out of Medicaid managed care (current FIDE states include CA, PA and NY) cannot pursue FIDE SNP designation. This may create a delay in transitioning from MMP to FIDE in certain states, such as MI.

  The mandatory cost-sharing benefit would improve administrative efficiency for providers and states and ostensibly, result in fewer providers electing not to serve dual eligible beneficiaries.

Rule Commentary Insights

→ CMS noted that 24 FIDE SNPs currently do not meet the new definition due to BH carve-out in their state and that enrollees would be permitted to remain in these plans, but the plans would be redesignated as either HIDE or coordination-only D-SNPs

→ CMS considered a requirement for real-time Medicaid FFS program and managed care plan enrollment data to D-SNPs, and will consider future rulemaking on this topic

→ CMS noted the intent with this provision to allow for clearer distinction between HIDE and FIDE SNP programs

→ Finalized as proposed (with minor clarifying change noted on slide 8):

- **Summary**
  In lieu of regulations referencing “coverage, consistent with State policy, of long-term services and supports, behavioral health services, or both,” CMS will codify limited carve-outs for FIDE and HIDE SNPs. FIDE or HIDE requirements will be met by Medicaid LTSS or behavioral health carve-outs that apply to a minority of enrollees or as a small part of the scope of services provided as approved by CMS. This is effective with the finalization of the Rule.

- **Impact**
  The threshold of permissible carve-out is still unclear given broad differences in Medicaid program design across states. Additional clarity (e.g., CMS indicating which state program designs currently meet this definition) would assist states and plans, as well as policy experts focused on advancing integrated programs.

Rule Commentary Insights

→ CMS reiterated and clarified that D-SNPs can meet the HIDE SNP definition through limited benefit Medicaid programs (prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs))

→ CMS’ intent with codifying limited carve-outs, rather than conveying these limits through sub-regulatory guidance, is to improve transparency of what the products are and to allow CMS to better enforce carve-out limits

→ Finalized as proposed:

- **Summary**
  A HIDE SNP's service area can be no greater than its Medicaid service area by 2025. This closes a loophole where D-SNPs qualified as HIDE (or FIDE, but due to exclusively aligned enrollment requirements, a FIDE SNP's service area will be automatically aligned as of 2025) by having a small portion of members in the same service area as the companion Medicaid plan. Medicare-Medicaid integration is only possible in overlapping services areas. FIDE and HIDE SNPs may still have larger Medicaid service area.

- **Impact**
  Without a modified Medicaid service area for certain HIDE SNPs, 106,000 beneficiaries in four states will lose access to HIDE-status D-SNPs. Depending on plan and state action, these D-SNPs will likely convert to a coordination-only D-SNP and be subject to notification requirements. Alignment in service area will clarify beneficiary choices and facilitate integration in member materials, plan processes, and beneficiary experiences.

Rule Commentary Insights

→ The states impacted by this provision currently all have coordination-only D-SNPs operating and so have experience in coordination-only notification requirements

→ CMS noted it agrees that D-SNP service areas should be completely aligned with the organization's Medicaid footprint, but currently is only mandating this alignment for HIDE and FIDE SNP programs

→ CMS acknowledged it is exploring ways to improve awareness of available integrated care options

→ Finalized as proposed

- **Summary**
  For states using exclusively aligned enrollment, CMS will revise its policy to only award one contract for each product type (e.g., HMO, PPO, RPPO) and instead, allow states to require an MA organization to create a separate contract that only includes one or more D-SNPs within the state. States pursuing this pathway will be able to pursue more integrated member materials, an integrated medical loss ratio (MLR), coordinated oversight and audits with CMS, and will receive access to HPMS.

- **Impact**
  A single contract ID reflecting a D-SNP organization in a single state has significant effects on integration. It would improve transparency and state oversight, and allow states to require a MOC specific to the state, a D-SNP specific provider network, assess Star Ratings specific to dual eligible individuals, and better align financial incentives through an integrated MLR. It would likely require initial administrative lift by plans and states.

Rule Commentary Insights

→ CMS expects that efforts to achieve D-SNP only contracts will take two years or more, and the earliest request for this pathway would be for plan year 2024

→ CMS acknowledged challenges with Star Rating methods that compare Medicare Advantage contracts with high dual eligible enrollment to contracts that enroll few dual eligible individuals, and that they will continue to monitor whether methodological changes are needed

→ In response to comments to expand this pathway to all states, CMS noted it will consider future rulemaking

→ For states using exclusively aligned enrollment and pursing a single contract structure:

- CMS will provide approved State Medicaid officials with access to the Health Plan Management System (HPMS) to support information sharing and oversight activities, including review of marketing materials, Models of Care, member complaints, plan benefits, formulary, network, and other basic D-SNP contract information. This will enable states to obtain critical information at the same time as CMS to facilitate greater state management and response to D-SNP operations.
- CMS will coordinate with States on an integrated Summary of Benefits, Formulary, and combined Provider and Pharmacy Directory as the minimum. CMS also intends to develop an integrated Member Handbook/Explanation of Coverage and Annual Notice of Change for contract year 2024 through a public comment process. Beneficiaries will have improved experiences through receipt of more seamless descriptions of their health care and pharmaceutical coverage, and a singular list of providers they can access. This will also provide SHIPs and similar beneficiary-support organizations with simplified resources to support members navigate and understand their coverage.
- States will be able to collaborate with CMS on oversight activities for D-SNPs and program audits. Program audit coordination will include CMS sharing major D-SNP audit findings with states and aligning review timing. CMS also intends to engage states in review of medical provider networks (exception request review).
- CMS will continue to explore the use of an integrated MLR and integrated rate development.

→ Finalized with clarification (italicized):

- **Summary**
  The definition of Applicable Integrated Plans subject to implementation of unified appeals and grievances procedures will expand, effective January 1, 2023, to include D-SNPs that meet the following:
  1. Have a policy to limit D-SNP enrollment to beneficiaries enrolled in an affiliated Medicaid MCO
  2. Fully aligned enrollment with Medicaid MCO
  3. Medicaid MCO contract which includes *primary and acute care; Medicare cost-sharing; and at least one of: Medicaid home health; medical supplies, equipment, and appliances; or nursing facility services*

- **Impact**
  Expansion of this definition would lead to implementation of unified appeals and grievance processes in more D-SNPs, positively impacting more beneficiaries. This would include extension of the protection of continuation of benefits pending an appeal to more beneficiaries. States and D-SNPs may have an administrative impact to implement.

Rule Commentary Insights

→ Currently, CMS believes it is not feasible to require unified appeals and grievances outside exclusively aligned plans (i.e., at the individual level for unaligned plans), but will continue to monitor for additional streamlining opportunities

→ CMS reminded D-SNPs that they must assist all enrollees with obtaining and appealing Medicaid benefits regardless of whether the benefits are covered by an unaffiliated Medicaid plan or FFS, outside the unified appeals and grievances process

→ Finalized with clarification (italicized):

- **Summary**
  MOOP limits for dual eligible beneficiaries will include third party payments (such as the state), even in instances where state lesser-of payment policy results in the state not paying an OOP cost (i.e., “accrued” costs). MA plans will be required to alert both the enrollee and the contracted provider(s) if an enrollee reaches the MOOP limit.

- **Impact**
  State spending on dual eligible beneficiary will decrease as a result of MOOP limits being attained sooner, and similarly, providers are more likely to be “made whole” by MA plans. As a result, providers ostensibly should be more willing to serve dual eligible beneficiaries. However, spending by MA plans will increase, with a higher impact on smaller MA plans and those with lower MOOPs as part of their benefit package, and potentially, supplemental benefits will decrease in response to MA OOP expenditures.

Rule Commentary Insights

- → CMS recognized the impact of this provision on MA bids, particularly for D-SNPs, and the potential to reduce rebates and consequently, supplemental benefits
- → CMS noted that most D-SNP organizations should be able to absorb the added costs of this provision by reducing their profit margin, while still attaining margin commensurate with or higher than their broader MA portfolio

→ Finalized with clarification:

- **Summary**
  The current capitated MMP program will end no later than December 31, 2025, and CMS will work with MMP states to develop a process to convert their programs to integrated D-SNPs. MMP programs in states choosing not to convert to an integrated D-SNP will end by December 31, 2023.

- **Impact**
  A key MMP authority currently not in D-SNP is Medicare shared savings. Without additional policy change or clarification, states will need to leverage less direct approaches to benefit financially from investments in integration, for example engaging in supplemental benefit design, rebasing Medicaid rates to reflect Medicare, integrated MLR reporting, and Model of Care/ clinical model design. States would benefit from further guidance on how much they can influence the Medicare dollar and the full extent of Medicaid authority, for example, whether states can require remittance on an integrated Medicaid MLR.

Rule Commentary Insights

→ CMS acknowledged the opportunity to continue demonstrations under its broader financial alignment initiative authority

→ CMS noted it is thinking through its broader waiver authority as part of the MMP to D-SNP transition, to ensure a seamless and successful transition

→ CMS acknowledged concerns with enrollment and integrated financing flexibilities lost with the transition away from MMP, and noted it will consider future opportunities to promote these flexibilities

D-SNP Types Subject to Key Provisions in the Proposed Rule

	FIDE SNP	HIDE SNP	CO-DSNP
Enrollee Advisory Committee	Required	Required	Required
HRA to include social risk factors	Required, 2024+	Required	Required
Exclusively aligned enrollment	Required, 2025+		
Medicaid risk for LTSS and BH	Required, 2025+		
Capitation for Medicare cost sharing, all dual eligible beneficiaries	Required	Recommended to states	Recommended to states
Unified appeals & grievances	Required, 2025+	Certain HIDEs	Certain CO-DSNPs
Continuation of Medicare benefits pending appeal	Required, 2025+	Certain HIDEs	Certain CO-DSNPs
Contract structure limited to D-SNPs	New opportunity, 2024+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
Integrated member materials	New opportunity, 2024+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
D-SNP Star rating and integrated MLR	New opportunity, 2024+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
Joint federal-state oversight	New opportunity, 2024+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
State HPMS Access	New opportunity, 2024+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs

Resources

- → Advancing Medicare-Medicaid Integration Through Medicaid Programs: A Policy Roadmap
- → Enhancing Medicare-Medicaid Integration: Bringing Elements of the FAI into DSNPs
- → Fixing the FIDE-SNP – Redefining "Fully Integrated"
- → Access to Medicare-Medicaid Integrated Products
- → Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections when Enrolled in Medicare Advantage
- → Is Too Much Choice a Bad Thing?
- → Key Beneficiary Protections in Medicare-Medicaid Integrated Programs
- → Advancing the Policy Environment to Address the Unique Needs of Partial Dual Eligible Beneficiaries
- → Transportation Access, Dual Eligibility, and COVID-19
- → Left Behind in the Era of Internet: Yet Another Challenge Facing Dual Eligible Beneficiaries
- → Making Sense of Medicare-Medicaid Integration Models
- → Medicaid-Capitated DSNPs: An Innovative Path to Medicare-Medicaid Integration
- → State Approaches Will Shape the Successes (and Failures) of New Supplemental Benefits in DSNPs

ATI has a library of resources on the current landscape of programs serving dual eligible beneficiaries, the unique needs and experiences of dual eligible beneficiaries, as well as recommendations to improve policy to better serve dual eligible beneficiaries.

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