

Medicare Advantage Proposed Rule: D-SNP and Dual Eligible Proposals

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Background and Purpose

On January 6, 2022, CMS released its Medicare Advantage and Part D proposed rule: *Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs* [CMS-4192-P].

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.

This deck is intended to provide stakeholders with a summary and insights into the key provisions impacting dual eligible beneficiaries. We will continue to update this resource with new insights as we analyze the Rule.

Navigate directly to a section of this Rule summary:

- [Enrollee Advisory Committee](#)
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- [FIDE SNP Definition \(enrollment, benefits\)](#)
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Key Definitions and Acronyms (current/pre-Rule)

CO-D-SNP	Coordination-only D-SNP, a designation for D-SNPs without an MCO with Medicaid risk for long-term services and supports (LTSS) or behavioral health (BH)
HIDE SNP	Highly-Integrated D-SNP; D-SNP organization also has Medicaid MCO risk for LTSS and/or BH in the state
FIDE SNP	Fully-Integrated D-SNP; D-SNP legal entity also has Medicaid MCO risk for at least 180 days of nursing facility coverage and, to the extent practicable by state law, other LTSS and BH in the state
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

Provision: Enrollee Advisory Committee

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.

Provision: SNP Health Risk Assessment (HRA)

Summary

SNPs will be required to include in the HRA standardized questions on key social determinants of health, including housing, food insecurity, and transportation described in upcoming guidance. CMS expressed interest in collecting standardized results but has not identified how, when, or whether they will require SNPs to report HRA data. HRA requirements will begin in 2024 or 2025.

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 standardized comments to minimize beneficiary and plan burden and should offer suggestions to CMS on preferred standardization.

Provision: FIDE SNP Exclusively Aligned Enrollment

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.

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. Aligned enrollment will promote integration by allowing FIDE SNP to provide all members unified materials and an integrated experience. States should continue to explore plan design to maximize FIDE frailty payments that are commensurate with LTSS level of need.

Provision: FIDE SNP Benefits

Summary

FIDE SNPs must cover Medicaid home health, durable medical equipment, and behavioral health beginning in 2025. FIDE SNPs must also cover all Medicaid primary care and acute care benefits including 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.

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.

Provision: FIDE and HIDE SNP Service Area

Summary

D-SNP service area can be no greater than Medicaid service area by 2025. This closes a loophole where D-SNPs qualified as FIDE or HIDE 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

In 2021, all FIDE SNPs, but not all HIDE SNPs met the proposed service area requirement. Without a modified Medicaid service area for these HIDE SNPs, this would impact 97,000 beneficiaries in four states losing HIDE status, and depending on plan and state action (e.g., converting to a CO-D-SNP), could result in these beneficiaries losing access to any D-SNP.

Alignment in service area should facilitate integration in member materials, plan processes, and beneficiary experiences.

Provision: FIDE and HIDE SNP Carve-Outs

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.

Impact

The threshold of permissible carve-out is still unclear. CMS notes personal care services would not be a permissible carve-out, but as an example, personal emergency response systems or home modifications would be permissible.

Additional clarity (e.g., CMS indicating which state program designs currently meet this definition or enumerating benefits) would assist states and plans.

Provision: D-SNP Supplemental Benefits

Summary

With the expansion of MA supplemental benefits to include non-medical services (such as LTSS and social service benefits), there is increased opportunity for overlap in D-SNP and Medicaid coverage. Supplemental benefits might be used to complement or otherwise fill gaps in Medicaid coverage. Currently, supplemental benefits are used before Medicaid pays for services dually covered by both programs. CMS is seeking comment on how states and D-SNPs can further coordinate supplemental benefits.

Impact

States will have clearer, and possibly greater, influence on D-SNPs supplemental benefits. However, supplemental benefit funding is considerably more limited than the cost of LTSS and social service benefits. Therefore, these benefits should not become a substitute for Medicaid coverage.

An increasing use of non-medical benefits in D-SNPs can help address individual needs prior to the beneficiary becoming fully eligible for Medicaid LTSS.

Provision: Exclusively Aligned Enrollment - Contract Structure

Summary

For states pursuing D-SNP exclusively aligned enrollment, CMS proposes to 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.

Impact

A single contract ID reflecting a D-SNP organization in a single state could improve transparency and state oversight, for example allowing better understanding of plan quality via Star Ratings, integrated MLR reporting, and clearer comparisons across D-SNPs. This would also allow for states to require a MOC that is specific to the state, and to review a D-SNP specific provider network. It may require an initial administrative lift by plans and states to implement, and would require plan crosswalk exceptions.

Provision: Exclusively Aligned Enrollment - State Information

Summary

For states using exclusively aligned enrollment and pursuing a single contract structure, CMS would 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 management information.

Impact

HPMS access would enable states to obtain critical information at the same time as CMS to facilitate greater state management and response to D-SNP operations. It will be important for CMS to provide accessible resources and training to State Medicaid officials to know how to use HPMS and manage analytic capabilities from its data. CMS should consider the value of allowing states to view and download information on all MA contracts, not just exclusively aligned D-SNPs.

Provision: Exclusively Aligned Enrollment - Marketing Materials

Summary

For states using exclusively aligned enrollment and pursuing a single contract structure, CMS proposes to create a pathway to coordinate with interested States an integrated Summary of Benefits, Formulary, and combined Provider and Pharmacy Directory. Inclusion of Explanation of Coverage and Annual Notice of Change documents are being considered but have different administrative hurdles to consider.

Impact

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.

Plans and states will have an administrative impact to develop tailored materials.

Provision: Exclusively Aligned Enrollment - Oversight and Program Audits

Summary

States using exclusively aligned enrollment and pursuing a single contract structure would have the opportunity 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 has also clarified it intends to use existing authority to engage states in review of medical provider networks.

Impact

States would have the opportunity to oversee compliance and performance of D-SNPs alongside of CMS. This would support state coordination of performance improvement projects with Medicaid priorities and benefits. It also has the potential for reduction in duplicative audits for plans.

Provision: Exclusively Aligned Enrollment - Financing

Summary

For states using exclusively aligned enrollment and pursuing a single contract structure, CMS would explore an integrated MLR. CMS also is interested in the potential interaction of D-SNP benefits and Medicaid cost/utilization in the evaluation of Medicaid managed care capitation rates for actuarial soundness.

Impact

Combining MA MLR information with Medicaid MLR data could provide a more complete picture of plan financial performance, to plans, states, and CMS. It is unclear how far a state's authority reaches if the integrated MLR (or D-SNP MLR) falls below a certain threshold (e.g., requiring reinvestment into enhanced benefits). CMS suggests a waiver might allow states and D-SNPs to calculate *and report* integrated MLRs rather than reporting separately for Medicaid and Medicare, but it isn't clear what waiver authority this would require.

Provision: Applicable Integrated Plan Definition

Summary

The definition of Applicable Integrated Plans subject to implementation of Unified Appeals and Grievances procedures would 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; either Medicaid home health, DME, or NF 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 plans will have an administrative impact to implement this unified process.

Provision: MA/D-SNP - MOOP

Summary

MOOP limits for dual eligible beneficiaries would 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.

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 should be more willing to serve dual eligible beneficiaries. However, spending by MA plans will increase, with a higher impact on MA plans with lower MOOPs as part of their benefit package, and potentially, supplemental benefits will decrease in response to MA OOP expenditures.

Provision: Converting MMPs to Integrated D-SNPs

Summary

While not an explicit proposal, CMS acknowledges that recent policy changes along with the proposed Rule “offer the opportunity to implement integrated care at a much broader scale than existed when MMPs were first created” and as a result, suggests they will work with capitated MMP states during CY2022 to develop a plan to convert MMPs into integrated D-SNPs, should the D-SNP provisions of the rule move forward.

Impact

D-SNP is more scalable than MMP, currently serving 47 states and nearly 4 million dual eligible beneficiaries. Transitioning from MMP/FAI into D-SNP could allow a larger number of dual eligible beneficiaries and states to access strong integration, given the D-SNP provisions in the proposed rule.

However, a key authority available in MMP but not directly available in D-SNP is state shared savings in Medicare. In D-SNP, states would need to leverage other, less direct approaches to benefit financially from their investments in integration, for example engaging in supplemental benefit design, rebasing Medicaid rates to reflect supplemental benefit design, 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 what the full extent of Medicaid waiver/1115 waiver authority might allow.

Provision: Forthcoming/Other

Summary

CMS is also proposing enhancements and modifications associated with appeals & grievances, partial-dual D-SNPs, Medicare Advantage cost plans operating alongside D-SNPs, and potential for states to offer real-time data exchange with D-SNPs.

Impact

More ATI analysis forthcoming.

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, 2024/2025	Required	Required
Exclusively aligned enrollment	Required, 2025+		
Medicaid risk for LTSS <i>and</i> 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, 2025+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
Integrated member materials	New opportunity, 2025+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
D-SNP Star rating and integrated MLR	New opportunity, 2025+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
Joint federal-state oversight	New opportunity, 2025+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs
State HPMS Access	New opportunity, 2025+	New opportunity, certain HIDEs	New opportunity, certain CO-DSNPs

*Required assumes the proposed rule is finalized as written

Other ATI Resources on Dual Eligible Beneficiaries

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.

Resources:

- [Enhancing Medicare-Medicaid Integration: Bringing Elements of the FAI into DSNPs](#)
- [Fixing the FIDE-SNP – Redefining “Fully Integrated”](#)
- [HCBS Spending Plans and the Untapped Potential of DSNPs](#)
- [Access to Medicare-Medicaid Integrated Products](#)
- [Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections when Enrolled in Medicare Advantage](#)
- [HCBS – Just One Piece of the Puzzle](#)
- [Is Too Much Choice a Bad Thing?](#)
- [A Brief Overview of 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](#)



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