ICRC | Integrated Care Resource Center

Helping states develop integrated programs for individuals who are dually eligible for Medicare and Medicaid

January 7, 2022

Announcing CMS CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P)

On January 6th, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would make updates to the Medicare Advantage (MA) and Medicare Part D programs, including proposals to improve experiences for dually eligible individuals who are enrolled in Dual Eligible Special Needs Plans (D-SNPs). The proposed rule seeks to incorporate many elements of the Financial Alignment Initiative into D-SNPs and the broader MA program that have improved experiences for dually eligible individuals.

States may want to comment as the CMS proposals lay out a number of pathways by which states can achieve improved coordination of Medicare and Medicaid benefits through both integrated D-SNPs and D-SNPs that are not currently contracted to deliver Medicaid benefits.

Comments on the Proposed Rule. The proposed rule will be published on January 12, 2022 in the *Federal Register*, and CMS will accept comments on the proposed rule received by March 7, 2022. To submit comments electronically, go to http://www.regulations.gov and follow the "Submit a comment" instructions referencing "CMS-4192-P."

To view the proposed rule, please visit: https://www.federalregister.gov/public-inspection

ICRC will send out an updated version of this e-alert on January 12, 2022 that will provide the specific page numbers in the version published in the *Federal Register* where each of these proposals is discussed in detail.

The D-SNP focused proposals include:

Enrollee Input on D-SNP Operations and Health Equity

CMS proposes all D-SNPs establish and maintain one or more enrollee advisory committees and that D-SNPs consult with advisory committees on issues related to health equity. The proposal builds on existing federal rules that require enrollee advisory processes among Medicaid long-term services and supports (LTSS) plans and Programs of All-Inclusive Care for the Elderly (PACE) organizations. CMS applies similar requirements for demonstration Medicare-Medicaid Plans (MMPs).

Social Determinants of Health and Special Needs Plan Health Risk Assessments

CMS proposes that all health risk assessments conducted by D-SNPs, as well as Chronic Condition SNPs and Institutional SNPs, include specific standardized questions on housing stability, food security, and access to transportation. This proposal would help better identify – and enable MA SNPs to take steps to address – the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence. Many dually eligible individuals contend with multiple social risk factors such as housing insecurity and homelessness, food insecurity, lack of access to transportation, and low levels of health literacy.

Simplified Appeals and Grievance Processes

CMS proposes to expand the universe of D-SNPs for which the unified appeals and grievance processes apply. The

Bipartisan Budget Act of 2018 charged CMS with unifying appeals and grievance processes across Medicare and Medicaid to the maximum extent possible. New requirements took effect in 2021 for a subset of D-SNPs. Beneficiaries in these plans go through one Medicare-Medicaid appeals process at the plan level, rather than filing separate, potentially duplicative, appeals with both the D-SNP and a Medicaid managed care organization (MCO). The proposal would simplify the appeals and grievance processes and extend the protection of continuation of benefits pending appeal to additional dually eligible individuals.

New Pathways to Simplify D-SNP Enrollee Materials

CMS proposes to codify a mechanism through which states can require certain D-SNPs to use integrated materials to make it easier to understand the full scope of Medicare and Medicaid benefits available through the D-SNPs. Currently, most D-SNP enrollees receive separate materials (e.g., provider directories) for their Medicare benefits and their Medicaid benefits, which can cause confusion among enrollees. With input from dually eligible individuals, CMS has integrated materials for demonstration programs and with a small number of D-SNPs to help people better understand their coverage.

New Pathways to Have Star Ratings Specific to the Performance of the Local D-SNP

CMS proposes to allow certain states with integrated care programs to require that MA organizations establish a contract that only includes one or more D-SNPs, which would allow for Star Ratings for that contract to reflect the D-SNPs' local performance. Star Ratings are calculated at the contract level for MA and Part D plans. In many cases, contracts contain D-SNPs and other non-SNP MA plans, which can make it impossible to fully assess the performance of a specific D-SNP within a specific state. This proposal is designed to identify disparities between D-SNPs and other MA plans and help CMS and states better drive quality improvement for dually eligible individuals.

Technical and Definitional Updates for FIDE SNPs and HIDE SNPs

CMS proposes revisions to the requirements for fully integrated D-SNPs (FIDE SNPs) and highly integrated D-SNPs (HIDE SNPs) to help beneficiaries, and the professionals that advise them, better understand what may be unique about a certain type of plan and what a beneficiary can expect from a plan. For plan year 2025, CMS proposes to require that all FIDE SNPs have exclusively aligned enrollment (i.e., limit enrollment to individuals in the affiliated Medicaid MCO) and cover Medicaid home health, durable medical equipment, and behavioral health services through a capitated contract with the state Medicaid agency. CMS also proposes to require each HIDE SNP's capitated contract with the state apply to the entire service area for the D-SNP. Consistent with existing policy, CMS proposes to codify specific limited benefit carve-outs for FIDE SNPs and HIDE SNPs.

Maximum Out-of-Pocket Policy for Dually Eligible Individuals

MA plans are required to establish a limit on beneficiary cost-sharing for Medicare Part A and B services after which the plan pays 100 percent of the service costs. Current guidance on calculation of the maximum out-of-pocket (MOOP) amount allows MA plans, including D-SNPs, the option to count only those amounts the individual enrollee is responsible for paying, net of any state responsibility or exemption from cost-sharing toward the MOOP limit, rather than the cost-sharing amounts for services the plan has established in its plan benefit package. In practice, this option does not cap the amount a state could pay for a dually eligible MA enrollee's Medicare cost-sharing. This results in state Medicaid programs paying more in Medicare cost-sharing for dually eligible enrollees than if the plan calculated attainment of the MOOP limit based on cost-sharing amounts for services in its plan benefit package.

CMS proposes to specify that the MOOP limit (after which the plan pays 100 percent of MA costs) in all MA plans, including D-SNPs, be calculated based on the accrual of all Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the beneficiary, Medicaid, or other secondary insurance, or remains unpaid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing. CMS projects that the change would save state Medicaid agencies $2 billion over 10 years while increasing payment to providers serving dually eligible individuals by $8 billion over 10 years.

Additional Proposals

This proposed rule would revise the MA and Part D regulations related to marketing and communications, the criteria used to review applications for new or expanded MA and Part D plans, provider network adequacy requirements, medical loss ratio reporting, special requirements during disasters or public emergencies, and the use of pharmacy price concessions to reduce beneficiary out of pocket costs for prescription drugs under Part D.

For a fact sheet detailing the CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P), please visit: https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-proposed-rule-cms-4192-p

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Proposals That Would Apply MMP Features Into D-SNPs

MMP Characteristic	FIDE SNP	HIDE SNP	Coordination-only D-SNP
Enrollee advisory committee	Propose to require	Propose same as FIDE	Propose same as FIDE
HRA to include social risk factors	Propose to require	Propose same as FIDE	Propose same as FIDE
Exclusively aligned enrollment	Propose to require starting 2025	-	-
Capitation for LTSS and behavioral health	Propose to require starting 2025	-	-
Capitation for Medicare cost-sharing	Propose to specify	-	-
Unified appeals & grievances	Propose to require starting 2025	-	Propose to require for certain plans
Continuation of Medicare benefits pending appeal	Propose to require starting 2025	-	Propose to require for certain plans
Integrated member materials	Propose to create a new pathway for states to require for certain plans	Propose same as FIDE	Propose same as FIDE
Contract only includes within-state plans limited to dually eligible individuals; quality data/ratings based solely on performance in contracts that only include within-state plans limited to dually eligible individuals	Propose to create a new pathway for states to require for certain plans	Propose same as FIDE	Propose same as FIDE
Mechanisms for joint federal-state oversight	Propose to establish for states meeting proposed criteria at § 422.107(e)	Propose same as FIDE	Propose same as FIDE

State HPMS access	Propose to establish for states meeting proposed criteria at § 422.107(e)	Propose same as FIDE	Propose same as FIDE