ICRC | Integrated Care Resource Center

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

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CMS Issues Final Rule on Contract Year 2023 MA and Part D Policy and Technical Changes

On April 29, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for the Medicare Advantage (MA) and Part D programs.

Several provisions affect Dual Eligible Special Needs Plans (D-SNPs) and dually eligible beneficiaries. Other provisions have broader applicability across MA and Part D. Many finalized policies are based on lessons learned from the Medicare-Medicaid Financial Alignment Initiative. We summarize the provisions focused on D-SNPs and dually eligible beneficiaries below. A more detailed description is available in the official CMS fact sheet.

ICRC released an e-alert summarizing the D-SNP and related provisions of the final rule on May 4, 2022. The summary below is identical to the summary in that e-alert but adds the page numbers from the version published in the May 9, 2022 *Federal Register* to facilitate access to the detailed discussions of those proposals.

Changes to D-SNP Regulations

- **Enrollee Input on D-SNP Operations -** Federal rules already require enrollee advisory committees for Medicaid managed care plans that cover Medicaid long-term services and supports and for Programs of All-Inclusive Care for the Elderly organizations, and CMS applies similar requirements for demonstration Medicare-Medicaid Plans. In this new final rule, starting in 2023 CMS requires all D-SNPs to establish and maintain one or more enrollee advisory committees for each state in which the D-SNP is offered and that D-SNPs consult with advisory committees on various issues, including ways to improve health equity for underserved populations.
    - For a discussion of comments received on the proposed rule, CMS responses, and a summary of the final provisions, see pp. 27718-27726.
- **Social Determinants of Health and Special Needs Plan (SNP) Health Risk Assessments -** 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. All SNPs must complete enrollee health risk assessments (HRAs) at enrollment and annually. Starting in 2024, this new final rule will require all SNP HRAs to include at least one question from a list of screening instruments specified by CMS in sub-regulatory guidance on housing stability, food security, and access to transportation, but CMS is not requiring that all SNPs use the same specific standardized questions. The final rule will help better identify the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence and enable MA SNPs to take these risk factors into account in enrollee care plans.
    - For details, see pp. 27726-27740.
- **Simplified Appeals and Grievance Processes -** The Bipartisan Budget Act of 2018 (Pub.L. 115–123) charged the Secretary of the Department of Health and Human Services with establishing unified appeals and grievance

procedures across Medicare and Medicaid to the maximum extent possible. New requirements took effect in 2021 for certain D-SNPs that enroll the same beneficiaries who receive their Medicaid coverage through an affiliated Medicaid managed care organization (MCO). 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 the Medicaid MCO. Through this final rule, starting in 2023 CMS is expanding the universe of D-SNPs for which the unified appeals and grievance processes apply, thereby simplifying the appeals and grievance processes and extending the protection of continuation of benefits pending appeal to additional dually eligible beneficiaries.

    - For details, see pp. 27778-27780.

- **New Pathways to Have Star Ratings Specific to the Performance of the Local D-SNP -** 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. In this rule, CMS finalizes a pathway 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 will allow for Star Ratings for that contract to reflect the D-SNPs' local performance. This provision of the final rule will help to more easily identify disparities between D-SNPs and other MA plans and help CMS and states better drive quality improvement for dually eligible beneficiaries.

    - For details, see pp. 27763-27768.

- **New Pathways to Simplify D-SNP Enrollee Materials -** Many dually eligible beneficiaries have low health literacy yet need to navigate a more complex system of coverage than non-dually eligible beneficiaries. Currently, most dully eligible beneficiaries receive separate materials (e.g., provider directories) for their Medicare benefits and their Medicaid benefits, which can cause confusion. With input from dually eligible individuals, CMS has successfully integrated many enrollee materials for demonstration programs and with a small number of D-SNPs to help people better understand their coverage. This final rule codifies a mechanism through which states can require the D-SNPs in D-SNP-only contracts to use integrated materials to make it easier to understand the full scope of Medicare and Medicaid benefits available through the D-SNPs.

    - For details, see pp. 27768-27773.

- **Technical and Definitional Updates for FIDE SNPs and HIDE SNPs -** This final rule requires, for 2025 and subsequent years, that all Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) have exclusively aligned enrollment (i.e., limit enrollment to individuals in the affiliated Medicaid MCO) and cover Medicare cost-sharing, long-term services and supports including coverage of nursing facility services and Medicaid home health, medical supplies, equipment and appliances, and Medicaid behavioral health services through a capitated contract with the state Medicaid agency. It also requires that each Highly Integrated Dual Eligible Special Needs Plan's (HIDE SNP's) capitated contract with the state apply to the entire service area for the D-SNP for plan year 2025 and subsequent years. It also codifies specific limited benefit carve-outs, consistent with existing policy, for FIDE SNPs and HIDE SNPs.

    - For details, see pp. 27740-27763.

Additional Key Changes

- **Maximum Out-of-Pocket Policy for Dually Eligible Beneficiaries -** Medicare Advantage (MA) plans are required to set 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 the option to count only those amounts the individual enrollee is responsible for paying, but not count any state cost-sharing payments or unpaid cost-sharing toward the MOOP limit, rather than all the cost-sharing amounts for services that 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, and 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.

This final rule specifies that the MOOP limit in an MA plan (after which the plan pays 100 percent of MA costs) is 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 (including when the cost-sharing is not paid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing). CMS projects that this change will save state Medicaid agencies $2 billion over ten years while increasing payment to providers serving dually eligible beneficiaries by $8 billion over 10 years.

  - For details, see pp. 27787-27795.

- **Marketing and Communications Oversight -** CMS is finalizing changes to marketing and communications requirements that will protect Medicare beneficiaries by ensuring they receive accurate and accessible information about Medicare coverage. These include strengthening oversight of third-party marketing organizations to detect and prevent the use of confusing or potentially misleading activities to enroll beneficiaries in MA and Part D plans, reinstating the inclusion of a multi-language insert in all required documents to inform beneficiaries of the availability of interpreter services, codifying enrollee ID card standards, requirements related to a disclaimer for limited access to preferred cost sharing pharmacies, plan website instructions on how to appoint a representative, and website posting of enrollment instructions and forms.

  - For details, see p. 27707.

- **Beneficiary Access to Care During Disasters and Emergencies -** To ensure that beneficiaries have uninterrupted access to needed services, CMS is revising and clarifying timeframes and standards associated with coverage obligations of MA plans during disasters and emergencies. Specifically, the final rule will clarify that an MA plan must comply with existing special requirements for disasters and emergencies when there is both a declaration of disaster or emergency (including a public health emergency) and disruption in access to health care in the MA plan's service area.

  - For details, see pp. 27798-27806.

- **Transition of Medicare-Medicaid Plans (MMPs) to Integrated D-SNPs -** Based on the comments received, and the new and amended regulations in this final rule, CMS will allow states interested in converting MMPs into integrated D-SNPs the opportunity to extend their demonstrations through 2025 under certain conditions and in order to ensure a smooth transition. These states should submit a transition plan outlining major policy and/or operational steps to CMS by October 1, 2022.

  - For details, see pp. 27796-27798. Table 1 on p. 27796 summarizes provisions in the final rule that apply MMP features to D-SNPs.

In addition to the provisions summarized above, the final rule revises the criteria used to review applications for new or expanded MA and Part D plans, including compliance with MA provider network adequacy requirements; quality ratings for MA and Part D plans; medical loss ratio reporting; and the use of pharmacy price concessions to reduce beneficiary out-of-pocket costs for prescription drugs under Part D. A more detailed description of the final rule is available in the official CMS fact sheet.