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CMS Moves Forward with its D-SNP Proposals in its CY 2023 Medicare Advantage and Part D Final Rule

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Continuing our series discussing the CY 2023 Medicare Advantage and Part D Final Rule (Final Rule), this post focuses on the D-SNP related provisions under the Final Rule. As we discussed, the Centers for Medicare & Medicaid Services (CMS) proposed significant modifications to its regulations governing Dual Eligible Special Needs Plans (D-SNPs). CMS finalized the majority of its proposals with limited modifications. This blog summarizes some of the key D-SNP provisions, focusing on the modifications from the proposed rule and CMS' commentary that provides insight into CMS' priorities and focus areas. Please refer to our prior post on D-SNPs for a more in-depth overview of the proposals.

Enrollee Participation in Plan Governance

CMS finalized proposed regulations requiring D-SNPs to establish an enrollee advisory committee. CMS is requiring that D-SNPs create one or more enrollee advisory committees that consist of "a reasonably representative sample of enrollees" *in each state* that the D-SNP operates. Meaning, if a D-SNP covers multiple states, it must establish multiple advisory committees so that each state has its own. Against the request of commenters to delay or at least phase-in this requirements, CMS is requiring all D-SNPs (rather than just a subset of D-SNPs) to implement these advisory committees effective January 1, 2023.

CMS did not establish specific requirements with respect to frequency, location, format, and participant recruiting and training methods for the committees. Through its responses to comments, CMS clarified that certain D-SNPs, and particularly Fully Integrated D-SNPs (FIDE SNPs) and D-SNPs with aligned membership that already have enrollee committees to meet state requirements, could rely on the same committee to meet the new federal requirements. CMS also clarified that D-SNPs may compensate plan members for participation on the enrollee advisory committee, so long as compensation is not cash, gifts, prizes, or other monetary rebates and does not otherwise violates fraud and abuse laws.

Housing, Food Insecurity, and Transportation Questions on the Health Risk Assessments

CMS finalized its proposal that all types of special needs plans (SNPs) must include questions regarding housing, food insecurity, and transportation on their health risk assessment (HRA) forms. In a change from the proposed rule, CMS is not requiring all SNPs to implement the same standard questions. Based on feedback from commenters, the Final Rule requires that SNPs include at least one question from a list of screening instruments specified by CMS on each of these three domains. CMS states that it will be issuing sub-regulatory guidance with the screening instruments by the end of 2022 to allow SNPs time to incorporate these questions into their HRA by the beginning of 2024.

Redefining Definitions for Fully Integrated and Highly Integrated D-SNPs

CMS acknowledged its current terminology and the nuances between FIDE SNPs and Highly Integrated D-SNPs (HIDE SNPs) are too complicated. In taking steps to clarify and better differentiate these types of D-SNPs, CMS finalized the following updates:

- *Exclusively Aligned Enrollment*. CMS finalized its proposal that all FIDE SNPs must have "exclusively aligned enrollment" by 2025 without modification. Under this requirement, only enrollees who are receiving Medicaid benefits from an affiliated Medicaid MCO of the same legal entity may enroll in the FIDE SNP. A subset of commenters recommended that CMS also extend "exclusively aligned enrollment" to HIDE SNPs. CMS declined to do so, noting this is outside the scope of the rule.

- *Scope of Services provided by FIDE and HIDE SNPs*. CMS finalized its definitions of FIDE and HIDE SNPs to clarify the scope of services each type of plan must provide and to better differentiate the plans. FIDE SNPs must cover Medicaid primary and acute care services, home health, durable medical equipment, and behavioral health services through a capitated contract with the State Medicaid agency. The changes to the definition of a HIDE SNP clarify that HIDE SNPs are required to cover, at a minimum, the full scope of the Medicaid benefit for Medicaid long-term services and supports or Medicaid behavioral health services (subject to limited carve outs).

- *Aligned Service Areas for HIDE- and FIDE-SNPs*. CMS also finalized its proposals to amend the definitions of FIDE and HIDE SNP so that, starting in 2025, all FIDE SNPs and HIDE SNPs must hold capitated contracts with the state Medicaid agency that cover the same service area for the D-SNP plan.

Stand-Alone D-SNP Contracts

CMS finalized its proposal to create a pathway for states to require D-SNPs with exclusively aligned enrollment to hold a "D-SNP only" contract. Medicare Advantage contracts are held at the legal entity level, with multiple plan benefit packages (PBPs) under one contract. As such, SNPs and non-SNPs may be PBPs in the same contract, with certain data only reported at the contract level (e.g., Star Ratings). This change allows the D-SNP PBPs to be under separate and stand-alone agreements so that this data reporting can be reported only for the D-SNP.

Commenters raised concern about this proposal, including (i) data integrity issues as D-SNPs may struggle to have sufficient sample sizes and (ii) fairness concerns, as D-SNPs will be compared against MA plans with limited dual-eligible enrollees. CMS responded by saying that it does not think the data will be unreliable based on its experience under the Financial Alignment Initiative. As to the

concern that dual-eligible individuals generally have lower Star Ratings given the population, CMS pointed to the Categorical Adjustment Index (CAI) currently used in the Star Ratings system to correct for this issue (even though it acknowledged that there is concern with the CAI) and said it would monitor the process.

In addition to the provisions discussed above, CMS also finalized changes to the calculations of the maximum out-of-pocket (MOOP) costs, requiring Medicare Advantage plans to count secondary coverage in calculating MOOP. We discussed this requirement in depth in the first blog of this series. We will be rounding out our series of the Final Rule with a final post on the non-D-SNP provisions.

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