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What Health Plans Should Know About Federal Changes for Dual Eligibles

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Introduction

Approximately 12 million people in the United States are dually eligible for both Medicare and Medicaid. Most dual-eligible individuals live below the poverty line and have complex health needs, including chronic conditions or limitations that require long-term services and supports (LTSS). Because dual-eligible individuals and health plans serving this population must navigate two disparate coverage programs, their care is often fragmented and uncoordinated, and managed care plans may lack the ability to effectively manage the "whole person" across the two programs. All of this increases the risk of poor health outcomes for an already vulnerable population and contributes to disproportionately high costs.

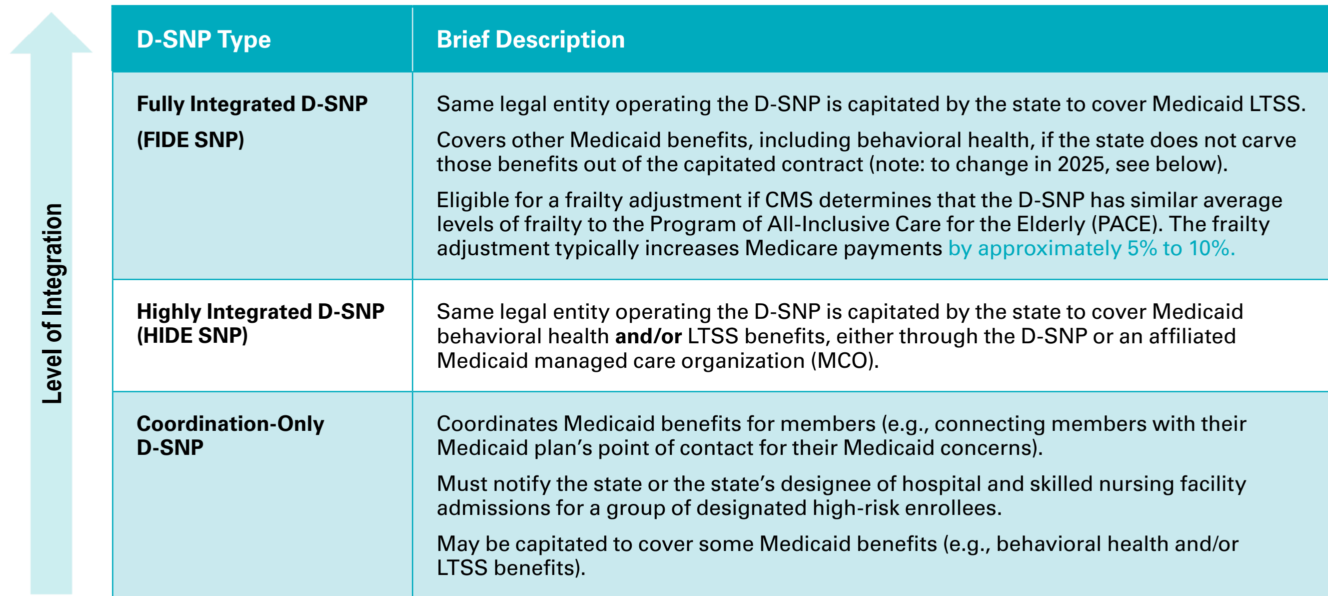
While these problems are years old, the Centers for Medicare & Medicaid Services (CMS) and the states are newly emphasizing a more integrated solution that puts a greater focus on managed care plans addressing the issue: Medicare Advantage (MA) dual-eligible special needs plans (D-SNPs), especially those considered "fully integrated" dual-eligible (FIDE) plans. Earlier this year, CMS released its Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs final rule. Under this rule, FIDE D-SNPs, or the health plans that offer them, are required to cover both Medicare and Medicaid benefits for the same enrollees and integrate their coverage. Compared with non-FIDE SNPs, FIDE SNPs will earn higher payments as they manage the continuum of covered benefits for their enrollees. But implementing FIDE SNPs requires states and plans to be active participants in developing new coverage models, which presents myriad policy, regulatory, and operational challenges, especially at the time that CMS is sunsetting other managed care models for duals.

This white paper highlights five key takeaways from the CMS final rule that have important implications for health plans already operating in or considering entering the fully integrated duals market.

D-SNP Overview

Designed to better coordinate care between Medicare and Medicaid programs, a D-SNP enrolls only dual-eligible individuals. First authorized in 2003, D-SNP enrollment has more than doubled in the past decade, to over 4 million, and is expected to continue to increase. There are three types of D-SNPs, each providing a different level of Medicare and Medicaid integration (see Graphic 1). With state approval, D-SNPs can automatically enroll Medicaid individuals who become newly eligible for Medicare if the D-SNP is from the same parent company as the individual's Medicaid managed care organization (MCO), making enrollment a more seamless process. As of March 2022, D-SNPs in ten states (AZ, CO, HI, KY, NY, OR, PA, TN, UT, VA) were approved to use this "default enrollment" mechanism.

Graphic 1: Types of D-SNPs



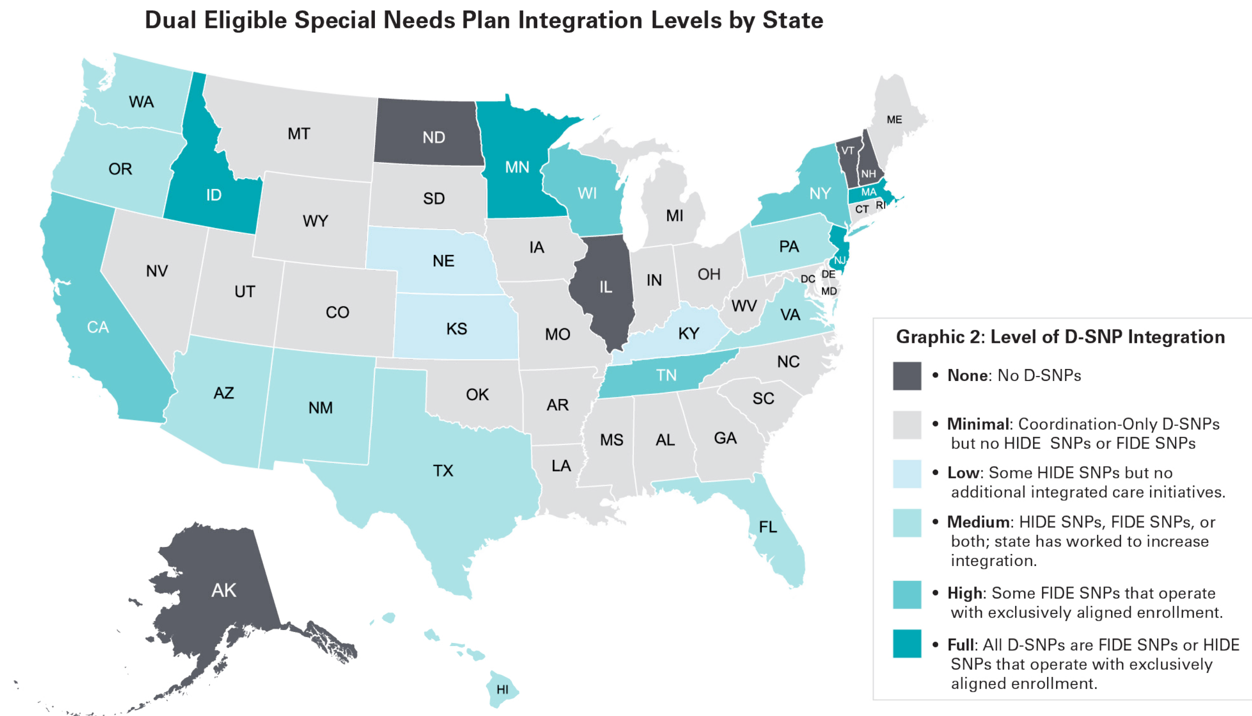
D-SNP Type	Brief Description
Fully Integrated D-SNP (FIDE SNP)	Same legal entity operating the D-SNP is capitated by the state to cover Medicaid LTSS. Covers other Medicaid benefits, including behavioral health, if the state does not carve those benefits out of the capitated contract (note: to change in 2025, see below). Eligible for a frailty adjustment if CMS determines that the D-SNP has similar average levels of frailty to the Program of All-Inclusive Care for the Elderly (PACE). The frailty adjustment typically increases Medicare payments by approximately 5% to 10%.
Highly Integrated D-SNP (HIDE SNP)	Same legal entity operating the D-SNP is capitated by the state to cover Medicaid behavioral health **and/or** LTSS benefits, either through the D-SNP or an affiliated Medicaid managed care organization (MCO).
Coordination-Only D-SNP	Coordinates Medicaid benefits for members (e.g., connecting members with their Medicaid plan's point of contact for their Medicaid concerns). Must notify the state or the state's designee of hospital and skilled nursing facility admissions for a group of designated high-risk enrollees. May be capitated to cover some Medicaid benefits (e.g., behavioral health and/or LTSS benefits).

CMS considers two types—FIDE SNPs and HIDE SNPs—as "integrated," though all D-SNPs must have executed contracts with state Medicaid agencies, referred to as a State Medicaid Agency Contract (SMAC), that meet minimum federal Medicare-Medicaid integration requirements. States have broad authority to impose additional, more robust requirements around Medicaid and Medicare integration for D-SNPs. CMS intends to monitor D-SNPs' compliance with federal requirements in future program audits to ensure enrollees receive integrated Medicare and Medicaid benefits.

Current D-SNP Market

As of October 2022, over 4.5 million dual-eligible individuals were enrolled in 730 D-SNPs nationwide—half of them in an integrated D-SNP (42% were enrolled in a HIDE SNP and 8% in a FIDE SNP). D-SNP access and integration levels vary widely across states. For example, in four states, all D-SNPs are either FIDE or HIDE SNPs that operate with exclusively aligned enrollment (meaning they can only enroll individuals who are enrolled in their affiliated Medicaid plan), while six states have no D-SNPs and 24 more have Coordination-Only D-SNPs (see Graphic 2).

Graphic 2: Level of D-SNP Integration



Source: Medicaid and CHIP Access and Payment Commission, Report to Congress on Medicaid and CHIP (June 2022).

To promote enrollment in truly integrated products, starting this year, CMS is not renewing contracts for D-SNP "look-alikes," MA plans that enroll primarily dual-eligible individuals but are not subject to regulations governing D-SNPs. As a result, an estimated 250,000 dual-eligible individuals will be disenrolled from D-SNP look-alikes and may seek D-SNP coverage.

The current D-SNP landscape, combined with CMS' defined preference for using FIDE and HIDE SNPs as the integration vehicles for the dual-eligible population, presents significant opportunities for health plans to establish or grow their dual-eligible coverage market presence.

Five Key Takeaways for Health Plans From 2023 CMS Medicare Final Rule

1. FIDE SNP enrollment will become more exclusive.

Current State: FIDE SNPs provide dual-eligible individuals access to Medicare and Medicaid benefits under a single legal entity that holds both an MA contract with CMS and a Medicaid MCO contract with a state Medicaid agency. Under this current definition, FIDE SNPs can accommodate unaligned enrollment, meaning that a FIDE SNP can provide Medicare benefits to enrollees who receive their Medicaid services through fee-for-service or another MCO. FIDE SNPs can also enroll partial-benefit dual-eligible individuals.

What's Changing: Starting in 2025, all FIDE SNPs will be required to have exclusively aligned enrollment—a FIDE SNP will only be able to enroll individuals who are receiving Medicaid coverage from the MA's affiliated Medicaid MCO. Notably, CMS is allowing states, through their SMACs, to require MA organizations to create separate D-SNP products—one for exclusively aligned enrollment and one or more other product(s) for unaligned enrollment—which would enable MA organizations to keep the FIDE SNP designation for the product with exclusively aligned enrollment. FIDE SNPs will also no longer be able to enroll partial-benefit dual-eligible individuals.

What This Means for Plans: Because some FIDE SNPs with unaligned enrollment may need to transition to a HIDE SNP status, such plans run the risk of losing the FIDE SNP frailty adjustment. While states can choose to allow MA organizations to keep their FIDE designation for a portion of enrollees—and thus maintain the frailty adjustment—this option adds a layer of administrative complexity for states and plans alike that may deter some from pursuing it. Plans operating FIDE SNPs should assess their current enrollment, gauge the interest of their state partners in this flexibility, and formulate a strategy around the potential need to split enrollment into separate D-SNPs.

2. FIDE SNPs will cover a broader array of services.

Current State: FIDE SNPs are required to provide primary care, acute care, LTSS, and behavioral health benefits, provided that the state includes behavioral health in its Medicaid capitation rate. CMS has allowed plans to meet the FIDE SNP designation even where states carve out Medicaid behavioral health services from the capitated contract.

What's Changing: Beginning in 2025, in addition to current benefits, FIDE SNPs will be required to cover Medicaid home health, medical supplies, equipment, and appliances, Medicare cost sharing, and behavioral health benefits.

What This Means for Plans: FIDE SNPs will no longer be able to operate in states that keep behavioral health carved out of Medicaid managed care, such as Pennsylvania, or move in the direction of a carve-out in the future. Current FIDE SNPs in Pennsylvania will be redesignated to HIDE SNPs and thus be ineligible for the frailty adjustment. Plans exploring expanding operations to new markets should carefully consider a state's Medicaid services landscape and coverage policy direction.

3. States will have the option to require standalone D-SNP contracts.

Current State: D-SNPs are included as separate MA plans, also known as plan benefit packages (PBPs), under the same contract number with other MA plans of the same product type offered by the MA organization. PBPs under a single contract may offer varying benefit packages and serve various populations across different states but still report certain quality measures at the contract level. As a result, it can be difficult to get a full picture of a D-SNP's quality performance distinct from other PBPs in the contract, such as performance on Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health and Outcomes Survey (HOS), and Star Ratings.

What's Changing: States that have D-SNPs with exclusively aligned enrollment will have the option to require MA organizations to seek CMS approval for standalone, state-specific D-SNP contracts. CMS notes that this contracting structure will help increase transparency, create clearer performance expectations for states, and enhance D-SNP oversight efforts. Due to timing of MA applications, bids, and contract execution, CMS anticipates that standalone D-SNP contracts established under this process will likely not take shape until plan year 2024. CMS will consider future rulemaking on whether to expand this flexibility to D-SNPs that do not have exclusively aligned enrollment.

What This Means for Plans: This flexibility may impose a potentially significant administrative burden on health plans to develop separate contracts and may be particularly disruptive for MA organizations with multistate contracts that include D-SNPs. The option also raises some concerns around appropriate quality and performance measures for standalone D-SNP contracts compared to MA contracts that serve fewer dual-eligible individuals. However, the flexibility also presents a potential market opportunity for those health plans that can distinguish themselves by providing high-quality care to D-SNP enrollees. Plans should have a position on the measures that most accurately reflect D-SNP performance and engage their federal and state partners in discussions around the measures.

4. With the sunset of the Financial Alignment Initiative (FAI), current Medicare-Medicaid Plans (MMPs) could transition to integrated D-SNPs.

Current State: For the past decade, CMS has used FAI MMPs to test models with states to better align Medicaid and Medicare financing and integrate comprehensive benefits for dual-eligible enrollees. In the popular capitated model, a state, CMS, and a health plan entered into a three-way contract, and the plan received a prospective blended payment to provide comprehensive, coordinated care. CMS and states also established savings percentages for Medicare Parts A and B and Medicaid that were applied equally to the two programs.

What's Changing: CMS will end the current capitated MMP program by no later than December 2025 and work with interested states to convert the existing 39 MMPs across nine states to integrated D-SNPs. CMS cited several changes in the integration landscape since the creation of MMPs that led to this decision, including growth of D-SNPs, experience gained through the FAI integrated grievances and appeals processes, and new Medicare benefit flexibilities addressing the social drivers of health, and noted that these changes provide opportunities to implement integrated care at a much broader scale than existed when MMPs were

first created. CMS seeks to leverage lessons learned from the FAI demonstration by applying many MMP features to D-SNPs (e.g., unified appeals and grievances, integrated member materials) through the 2023 final rule (see the Appendix for more details). States interested in converting their MMPs to integrated D-SNPs were required to submit a transition plan to CMS by October 1, 2022. CMS will work with any state opting to forgo the conversion on an appropriate MMP conclusion by December 2023.

What This Means for Plans: Plans currently offering an MMP will be forced to wind down or convert their product in line with the state's MMP transition planning. Prior to CMS' decision to end the MMP program, participating FAI states may have been less inclined to stand up D-SNPs in order to maximize dual-eligible enrollment in MMPs. As MMPs sunset, these states may choose to procure D-SNPs, presenting an opportunity for new market entrants or plan expansions. Of the nine states participating in the FAI demonstration, five do not currently have any FIDE or HIDE SNPs (IL, MI, OH, RI, and SC).

Further, with the end of the FAI demonstration, states may lose the opportunity to share in Medicare savings with CMS, a key demonstration authority. As a result, state officials may explore other approaches to achieving savings from investments in integration. For example, states may require FIDE SNPs to cover supplemental benefits that generate Medicaid cost savings, and state actuaries can consider the impact of MA supplemental benefits and other state-specific requirements on the projected costs and utilization of Medicaid benefits when developing their Medicaid managed care rates.

5. D-SNPs will be required to solicit enrollee input on the plan.

Current State: There are currently no federal requirements for D-SNP enrollee advisory committees.

What's Changing: Effective January 1, 2023, MA organizations offering a D-SNP will need to establish one or more enrollee advisory committees in each state to solicit direct input on ways to improve access to covered services, coordination of services, and health equity among underserved populations. D-SNPs will have flexibility to determine the frequency, location, and participant criteria for enrollee advisory committees. CMS will update its D-SNP audit protocols to monitor the extent to which MA organizations are meeting enrollee advisory committee requirements and could consider more prescriptive requirements, as needed, in the future. Additionally, state Medicaid agencies have the flexibility to include more prescriptive parameters for enrollee advisory committees in their contracts with D-SNPs.

What This Means for Plans: Plans should identify potential alignment with and draw on best practices from other existing enrollee engagement efforts. Since dual-eligible individuals are more racially diverse than Medicare-only individuals, plans should ensure their enrollee advisory committees adequately reflect the demographic diversity of their enrolled populations.

Conclusion

Federal changes to dual-eligible coverage programs are complicated by the broad authority of states to shape their D-SNP markets. Many factors—ranging from Medicaid benefit design to the levels of Medicare expertise and bandwidth among state regulators—can impact state decisions to advance integration through D-SNPs. To set themselves up for success, health plans should leverage opportunities to engage with and educate state officials on the potential of integrated D-SNPs to effectively manage the complex needs of dual-eligible individuals. Plans should also take stock of the characteristics that can help strengthen their position as attractive partners to states, such as a "whole-person" care approach that addresses social drivers of health, commitment to advancing health equity, focus on quality improvement, openness to innovation, and active enrollee engagement. Understanding both the numerous changes in federal dual-eligible coverage policy and the specific state context is crucial to the long-term success of any D-SNP.

Example State Factors Driving D-SNP Market Changes

- Does the state include behavioral health and long-term services and supports in its Medicaid managed care program?
- Does the state have an existing duals demonstration program?
- With which types of D-SNPs is the state currently contracting?
- Will the state require D-SNPs to have a separate MA contract?

Appendix: Proposals Finalized in CMS 2023 Final Rule That Apply MMP Features to D-SNPs

MMP Characteristic	FIDE SNP	HIDE SNP	Coordination-Only D-SNP
Enrollee advisory committee	Required	Same as FIDE	Same as FIDE
HRA to include social risk factors	Required	Same as FIDE	Same as FIDE
Exclusively aligned enrollment	Required starting 2025	Not addressed in this rulemaking	Not addressed in this rulemaking
Capitation for LTSS and behavioral health	Required starting 2025	Not addressed in this rulemaking	Not addressed in this rulemaking
Capitation for Medicare cost-sharing	Required starting 2025	Not addressed in this rulemaking	Not addressed in this rulemaking
Unified appeals and grievances	Required starting 2025 for all FIDE SNPs	Not addressed in this rulemaking	Required for certain plans
Continuation of Medicare benefits pending appeal	Required starting 2025 for all FIDE SNPs	Not addressed in this rulemaking	Required for certain plans
Integrated member materials	Finalized a new pathway for states to require for certain plans	Same as FIDE	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**	Finalized a new pathway for states to require for certain plans	Same as FIDE	Same as FIDE
Mechanisms for joint federal-state oversight	Finalized for states meeting specified criteria at § 422.107(e)	Same as FIDE	Same as FIDE
State Health Plan Management System (HPMS) access	Finalized for states meeting specified criteria at § 422 107(e)	Same as FIDE	Same as FIDE

Source: 87 FR 27704.

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