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Special needs plans integration, coordination, and equity: Understanding regulatory changes

by Nancy Erickson, RN, BSN, MHA

In recent years, the Centers for Medicare & Medicaid Services (CMS) has been increasing its focus on special needs plans (SNPs) and, most recently, on dual SNPs (D–SNPs). There are several reasons for this increased focus. First, this is partly due to CMS' perception that "special" attention was lacking in these plans and the plans were not meeting the original intent of the SNP plan design. Enrollees in these plans should receive more integration and coordination in their services, as they have higher needs. In addition, with the new health equity focus by CMS, this population needs more attention for D–SNP to ensure health equity and coordination between Medicaid and Medicare services. In May 2022, CMS finalized a rule that sunsets an existing integrated care mode: the Medicare–Medicaid plans (MMPs) under the Financial Alignment Initiative, with a transition of MMP enrollees to integrate Medicare Advantage (MA) D–SNPs by 2025. This means there will be more vulnerable enrollees served under D–SNPs. Now is the time to ensure that your SNP enrollees—especially your D–SNP enrollees—get robust and integrated services under your SNP program.

CMS' intent overall is about improving the experience for dual eligible beneficiaries. CMS has implemented several efforts to streamline and align a wide variety of Medicare and Medicaid regulations, policies, and operations. Their stated goal is to bridge the experience more effectively for dual eligible beneficiaries between the MMPs. New requirements, which began this year, provide evidence that CMS is moving to ensure that the dual eligible population has a more seamless and integrated experience. Trying to navigate two systems can be daunting for this underserved population and their unique needs.

CMS requirements for 2023 success and beyond

Under the 2023 final rule (CMS-4192-F), CMS codified that enrollees have an opportunity to be active in plan governance. Beginning January 1, 2023, all D–SNPs must ensure they have an enrollee advisory committee to solicit direct input from their enrollees about needs and programs.[1] As with most regulations, CMS is not prescriptive in specifics of the committee, leaving that up to the plan to design. Going forward, CMS has said it will be assessed during D–SNP program audits and has stated the protocols will be updated. To meet this requirement, plans may ask themselves:

- How did or are we implementing this requirement?
- Do we have a committee established?
- Do we have a formal charter with accountabilities and meeting frequency?

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The most difficult part of implementing these requirements may be strategies to gain enrollee engagement in the committee. This population is challenging to access care management, and many plans struggle to contact enrollees regarding their basic healthcare needs. Involving members in plan governance will require even more outreach and coordination. Recommendations include clearly communicating that you want them to have a voice in their plan, which may lead to success; however, plans should also consider having convenient meetings that offer enrollees an incentive to participate in the meetings—a light meal, a gift card, or other reward and incentive. This is not currently part of the program audits we have experienced; however, it is expected in 2024.

CMS has further integrated the MMPs for D–SNP by offering states more opportunities through their two-way contracts with D–SNPs who have exclusively aligned enrollment to become more integrated and transparent with the state. Currently, many states have "coordination only" for their D–SNP that may only require some reporting by the plan. The flexibilities outlined in the new rule provide opportunities for more integration and transparency between states and CMS. There are benefits to both D–SNPs and states to this part of the new rule:

- CMS is now coordinating with states that desire to implement an integrated summary of benefits, formulary, and a combined provider and pharmacy directory for both programs.
- CMS now allows states access to the Health Plan Management System to view the same data/information on D–SNP that is available to CMS to ensure states are aware of D–SNP performance.
- CMS is now coordinating with state Medicaid officials on program audits and include them in entrance and exit conferences during program audits.

We experienced this firsthand during the program audits conducted in 2023. The regional office account manager must participate in the entrance and exit conferences. CMS is working more closely with state Medicaid agencies to not schedule Medicaid audits at the same time as Medicare audits, which is a benefit to the plans as well as the agencies.

Under the final rule, CMS is now allowing 1876 cost plans to offer a D–SNP in the same service area as the cost plan, which has not previously been allowed. This may lead to additional D–SNPs in expanded service areas and make for a more competitive landscape for D–SNP enrollees to choose from.

Applicable integrated plan tool expands the integration

In the final rule, effective January 1, 2023, CMS also clarified and enhanced the previously promulgated definition of an applicable integrated plan (AIP) as another tool to expand the integration for dual eligible beneficiaries. As the MMPs wind down, this provides the integration CMS is looking for in D–SNPs. The definition has been expanded to include certain combinations of Medicaid managed care plans and D–SNPs that are not fully integrated dual eligible SNPs or highly integrated dual eligible SNPs but which meet the following three conditions:

1. State policy limits the D–SNP's enrollment to beneficiaries enrolled in an affiliated Medicaid managed care plan that provides the beneficiary's Medicaid managed care benefits;
2. Each enrollee's Medicaid managed care benefits must be covered under a capitated contract between the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization; and a Medicaid managed care organization or the state Medicaid agency;
3. Medicaid coverage under the capitated contract must include primary care and acute care, including Medicare cost-sharing, without regard to the limitation of that definition to qualified Medicare

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beneficiaries; *and* at least one of the following: Medicaid home health services, Medicaid durable medical equipment, or Medicaid nursing facility services.

In addition, the rule codified the requirement that AIPs must provide enrollees with integrated grievance or appeal with information on how evidence and testimony should be presented to the plan and clarifies other requirements around prompt pay and integrated reconsiderations (processing timeframes, who may request, etc.). These simply codify what was already outlined in the updated August 2022 *Medicare Managed Care Manual* Addendum to the Parts C and D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for AIPs as set forth at 42 C.F.R. §§ 422.629–634, which apply to applicable integrated plans as defined in 42 C.F.R. § 422.561.

Maximum out-of-pocket change in calculation

An interesting item added in the final rule, effective January 1, 2023, was a change in the maximum out-of-pocket (MOOP) calculation for dual eligible enrollees. This item may have slipped your plan's notice, but this is something plans must be sure they are doing! The change in calculation impacts not only SNP but all dual eligibles in any MA prescription drug plan. Historically, the MOOP was only applied to enrollees who paid cost-share; since most dual eligible enrollees have their cost-share paid by Medicaid, this was not accounted for and was a cost to the state Medicaid programs. Now, all costs for Medicare Parts A and B services accrued under the plan benefit package for MA plans will be counted towards the MOOP limit, including dual eligible enrollees. This includes cost-sharing paid by any applicable secondary or supplemental insurance (such as through Medicaid, employer(s), and commercial insurance), cost-sharing that remains unpaid because of limits on Medicaid liability for Medicare cost-sharing under lesser-of policy, and the cost-sharing protections afforded certain dually eligible individuals. Therefore, once the third party has paid the cost-share up to the MOOP, the plan is responsible for the full charge. All plans require a change in plan claims processing and MOOP assessment, but D–SNPs are impacted for all enrollees. Plans must ensure their MOOP calculations are being conducted for all enrollees. If you already have it set up to calculate for all, you can simply apply it to those enrollees. If you had not included dual eligibles in that setup, your coding needs to be modified to include those enrollees.

Model of care new focus

CMS also reiterated by codification certain requirements governing care management, which were already promulgated in the 2022 final rule. For those who submitted their renewal model of care (MOC) in February 2022 for the 2023 plan year or February 2023 for the 2024 plan year, CMS and the National Committee for Quality Assurance (NCQA) already required additional care management requirements. If you have a renewal coming up in February 2024 for the 2025 plan year, these requirements will need to be implemented. Plans should note that these requirements are not only for the MOC document but include processes that are required and are being assessed in 2023. A best practice is to redline your MOC and implement these processes now to ensure compliance—do not wait for your renewal!

Requirements include:

- The interdisciplinary care team (ICT) must include providers with demonstrated expertise, including training in an applicable specialty in treating individuals similar to the targeted population of the plan. This may not be a new requirement, but it does clarify the intent that ICT providers should be appropriate for the needs of each enrollee. Many plans now use standard ICT membership without regard to the unique needs of each enrollee. While a core ICT can be the same (the enrollee, the case manager, and/or the primary care provider (PCP)), each enrollee's ICT should vary depending on their specific health needs. For instance, some enrollees may need a social worker, specialist, or pharmacist on their ICT.

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- Face-to-face encounters for the delivery of healthcare, care management, or care coordination services must be conducted in-person or via visual, real-time, interactive telehealth technology between each enrollee and a member of the enrollee's ICT or the plan's case management and coordination staff at least annually—beginning within the first 12 months of enrollment—as feasible and with the enrollee's consent. CMS has documented little engagement and active care management with this vulnerable population during audits. This requirement ensures that plans must make at least one face-to-face visit with the enrollee per year—actually laying eyes on them! Plans must not only describe how they fulfill this requirement in the MOC and be able to evidence this during the audit. It cannot be just telephonic; if telehealth, it must include video as well. If a plan had the PCP as a member of the ICT for all enrollees, many of these plans would use an annual PCP visit to accomplish the face-to-face encounter. However, you need to ensure the PCP is aware of this requirement and has been trained to conduct an appropriate review of the individualized care plan (ICP) with the enrollee, including assessment of their needs. Another tactic for plans is to have face-to-face visits with the care manager. There are many ways to meet this requirement, but it must be documented and evidenced.

- The initial assessment and annual reassessment results required for each enrollee must be addressed in the enrollee's ICP. This is not new guidance but is being reinforced in this rule. Many plans have started using automated ICP development from the health risk assessment (HRA) algorithms, and unfortunately, CMS continues to see in audits many conditions/needs not addressed. This continues to be a common condition in SNP audits, which we saw throughout the 2023 audit season. CMS does not like "cookie cutter" care plans; they are looking for truly *individualized* care plans. Many plans that have already experienced this observation or condition from an audit have chosen continued use of the technology and added a registered nurse to review and individualize for each enrollee. This process can be a reasonable starting point but should only be a foundation for the care management team to develop the complete ICP.

- The evaluation and approval of the MOC by NCQA now considers whether the plan fulfilled its previous MOC goals. Plans must be able to track their D–SNP goals in MOC element four year-over-year as part of the qualifying individual (QI) program. They also need to track whether the goal was met and, if not met, what actions are being taken to improve the following year. This standard QI evaluation process should have already been included in plans, but NCQA is now more prescriptive for the SNP to specifically address in their MOC documents. If you have an MOC renewal due February 2024, be aware that we have seen this be an area of concern during MOC scoring.

- While not required under the final rule until 2024, HRAs will be required to include questions on housing, food insecurity, and transportation using questions from CMS-approved tools. CMS has provided the tools allowed, and plans should include those tools now to ensure compliance and the ability to address the social needs of this vulnerable population. Plans can use state tools, assuming those tools already address all three of the required aforementioned issues. Many plans already include questions in these areas, but you will want to check the CMS tools and ensure they use the approved questions.

The final rule also called out the minimum scoring of the MOC, which now requires that in addition to the minimum overall scoring benchmark, plans must also obtain a minimum score of 50% for each element to obtain approval, *regardless of the final overall score* and will be required to cure. This was codified in 42 C.F.R. § 422.101 (f)(3)(iii). This was evidenced in MOC reviews for clients last year and this year who had failures in MOC 1 and MOC 4, in particular. This likely occurred because plans have typically focused on MOC 2 and MOC3, which comprise the bulk of the SNP program and have historically received more scrutiny. Specifically, the two factors causing scoring issues are MOC 1, Element B: Sub-Population: Most Vulnerable Enrollees, and MOC 4, Element B: Measurable Goals & Health Outcomes for the MOC.

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It is pertinent to note that the MOC scoring requirements have been updated to ensure plans have clearly articulated their program and meet the requirements.

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