

## CMS Regulations Set Ground Rules for D-SNPs

Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage plans that limit enrollment to people eligible for both Medicare and Medicaid. The Bipartisan Budget Act of 2018 (2018 BBA) permanently authorized D-SNPs and also directed the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS) to adopt regulations that set minimum D-SNP requirements to integrate Medicare and Medicaid benefits. CMS recently finalized those regulations. This fact sheet reviews key elements of the [final D-SNP regulations](#) including:

- Minimum responsibilities for D-SNPs to coordinate Medicaid benefits
- Requirements for integrating Medicare and Medicaid appeals
- Duty to notify state Medicaid programs of hospital admissions
- Enrollment of partial duals in D-SNPs
- Enforcement options for CMS

The final regulations will apply to the plan year 2021. CMS intends to issue subregulatory guidance that will provide more specific guidance to D-SNPs about their obligations.

### Coordination Responsibilities of D-SNPs

All D-SNPs must have contracts with state Medicaid agencies laying out D-SNP responsibilities to coordinate Medicare and Medicaid benefits. The regulations provide that state contracts require that D-SNPs “coordinate the delivery of Medicaid benefits.” In commentary, CMS clarified that this requires that D-SNPs at a minimum must offer their members assistance in obtaining Medicaid covered services and resolving grievances, requesting authorization of Medicaid services, and navigating the Medicaid appeals process. As needed, the D-SNP must, for example, help the member identify the member’s Medicaid plan’s point of contact for the member’s Medicaid concern, assist in filling out forms, and assist in obtaining documentation for filing a Medicaid appeal. The D-SNP must offer the assistance whenever it becomes aware of a need and may not just wait until a member makes a request.

These requirements apply to all D-SNPs, regardless of how the D-SNP’s members receive their Medicaid benefits. Depending on state requirements and individual choice, D-SNP members might receive their Medicaid benefits through fee-for-service, through a matching managed care plan operated by the same sponsor as the D-SNP, or through a managed care plan operated by a different sponsor.

#### Advocacy Note

CMS emphasized that these are minimum requirements that must be included in all contracts between states and D-SNPs. States, however, may be more specific and prescriptive and may add other requirements to promote integration of Medicare and Medicaid and assist beneficiaries with navigating the two programs. We encourage advocates to engage with their state Medicaid agency to ensure that the coordination provisions in their state’s D-SNP contracts are robust and enforceable.

## Integrated Appeals

For a limited subset of D-SNPs, the regulations also require an integrated appeal system at the plan level. This means that, with both an organizational determination and a plan redetermination, the D-SNP will review a coverage request under both Medicare and Medicaid criteria, using a single set of deadlines and integrated notices to the member. Members can receive aid-paid-pending for both Medicaid and Medicare services, without potential recoupment, through the issuance of a redetermination decision. All timeframes and other requirements are based on the requirements—Medicare or Medicaid—that are more beneficial to the member. The regulations do not require integration beyond the plan reconsideration level. Plans must also use integrated processes to handle grievances.

### New D-SNP Category

In developing these rules, CMS created a definition for a new D-SNP category, the Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP). To be considered a HIDE-SNP, a plan must provide, either directly or through a companion Medicaid managed care plan, either Long-term Services and Supports (LTSS) or behavioral health services as well as other Medicaid services to its dual eligible members. This contrasts with a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) which provides virtually all Medicaid services including both LTSS and behavioral health.

The integrated appeals process only applies to HIDE-SNPs and FIDE-SNPs in states that require exclusively aligned enrollment, that is, where state policy limits a D-SNP's membership to individuals receiving their Medicaid benefits through a managed care entity operated by the same plan sponsor. According to CMS, there currently are 37 plans in eight states that would be covered, serving approximately 150,000 beneficiaries. These states are: Florida, Idaho, Massachusetts, Minnesota, New Jersey, New York, Tennessee and Wisconsin.

### Advocacy Note

Although CMS limited the requirements for integrated appeals to a discrete group of D-SNPs, the agency also encouraged states to explore other more limited steps to make appeals for overlapping services easier for beneficiaries enrolled in other D-SNPs. We urge advocates to work with their states to develop at least partial appeals integration. For example, D-SNPs with matching Medicaid plans, even if not exclusively aligned, could provide integrated appeals for that portion of their membership that is enrolled in the matching plan. All D-SNPs could provide appeal notices that clearly explain to members the path for pursuing the Medicaid side of an appeal.

On the flip side, advocates could work with their states to modify Medicaid managed care contract terms so that, where the Medicaid rules are more restrictive, they are replaced by those applying to D-SNP appeals. The integrated appeal rules (42 C.F.R. §§ 422.629-422.633 and accompanying commentary) provide a good roadmap for comparing plan-level Medicare and Medicaid appeal rules.

## Notification of Hospital Admissions

The 2018 BBA directed CMS to set regulations requiring that D-SNPs must notify the state or its designee of hospital and skilled nursing facility admissions of plan members. CMS applied this mandate narrowly, only requiring states to identify at least one group of high-risk full duals and to implement the notification requirement for that subgroup. CMS opted for this relatively limited regulation because of agency concerns that data exchange capabilities and processes vary greatly among states and plans.

### Advocacy Note

Because coordination of benefits during discharge planning is particularly critical for a successful transition, all D-SNPs should have systems in place to ensure both care and benefit coordination for members leaving institutional settings. We encourage advocates to work with their states to ensure that D-SNPs are contractually required to have such systems. As important, states need to make sure that Medicaid providers and plans have their own systems in place to receive notifications of admission and discharge and to coordinate with D-SNPs and discharge planners.

## Partial Duals and D-SNPs

In issuing the regulations, CMS indicated that it questioned the value of enrollment of “partial duals” in D-SNPs. Partial duals are individuals who do not qualify for full Medicaid benefits but are only enrolled in a Medicare Savings Program (QMB, SLMB or QI) that pays Medicare premiums. Because these individuals are not eligible to receive any Medicaid-covered services, there is concern whether D-SNP enrollment provides any added value and whether D-SNPs are appropriate for this population. CMS indicated that it may consider future rulemaking in this area.

### Advocacy Note

Some states have chosen to restrict D-SNP enrollment for partial duals but many have not. We share with CMS skepticism about the value of D-SNPs for partial duals and would appreciate any information or insights advocates may have on how partial duals are faring in D-SNPs in your state.

## Enforcement

The new rules allow CMS to impose intermediate sanctions, such as suspension of enrollment on D-SNPs in violation of the integration regulations.

### Advocacy Note

The regulation allows CMS to restrict enrollment in a D-SNP that is not meeting integration standards even if the violation does not rise to the level of making a serious threat to the health and safety of enrollees. This gives CMS more leverage to ensure full implementation of integration standards. Advocates should alert CMS to problems they see on the ground so that the agency can get a better understanding of how integration standards are being implemented.

## Conclusion

The D-SNP regulations discussed in this factsheet are part of a [larger rulemaking](#) that includes requirements for Medicare Advantage plans offering telehealth benefits; Medicare Advantage and Part D plan quality rating systems; and revisions to the procedures and policies for preclusion of providers and prescribers in Medicare Advantage, Part D plans, Cost Plans, and PACE.

Advocates with questions about this fact sheet or seeking technical assistance should contact Justice in Aging at [info@justiceinaging.org](mailto:info@justiceinaging.org).