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Upcoming Changes for Dually Eligible Individuals–the Final 2025 Medicare Advantage Rule

Webinar Transcript

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Rachel Gershon,...: Hello and welcome everyone. My name is Rachel Gershon and I'm a Senior Attorney at Justice in Aging. Today we are presenting a webinar on Upcoming Changes for Dually Eligible Individuals: The Final 2025 Medicare Advantage Rule. I'm joined by my esteemed colleague, Tiffany Huyenh-Cho. She's the director of California Medicare and Medicaid Advocacy. Before we begin, I just want to acknowledge this is a particularly complicated area. We are going to have lots of time for questions at the end, and we're also welcome to chat about this anytime. And in addition to this webinar, we have slides that will be available. I think there'll be a link in the chat. And in addition to that, tomorrow there's going to be a brief that is published as well, a issue brief. And I think we might have the link for that early for you as well.

All right. So a little bit about Justice in Aging. Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. Since 1972, we focused our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ+ individuals, and people with limited English proficiency. Justice in Aging has a commitment to advancing equity. We must advance equity for low income older adults in economic security, healthcare, housing, and elder justice initiatives. We must address the enduring harms and inequities caused by systematic racism and other forms of discrimination that uniquely impact low-income adults in marginalized communities. And finally, we must recruit, support and retain a diverse staff and board, including diversity across race, ethnicity, gender, gender identity and presentation, sexual orientation, disability, age, and economic class.

A little bit of housekeeping before we start the subject matter of the webinar. All of you are on mute. Please use the questions format for substantive questions and for technical concerns. If you are having problems with getting on

the webinar, you can send an email to trainings@justiceinaging.org. You can find materials for this training and past trainings by searching our resource library. And a recording will be posted to Justice in Aging's Vimeo page at the conclusion of this presentation. All of the links on this slide, if they're not working for you in Webinar, you can grab the link to the slides online and those links should be working. And in order, if you want to enable close captioning, you can select CC from the Zoom control panel.

If you want to receive Justice in Aging training and materials, please join our network. Go to justiceinaging.org and hit sign up. Or you can send an email to info@justiceinaging.org. All right, so our agenda. We're going to do an overview and a glossary of terms, just because this rule is so complicated, we need a little bit of a level setting on what terms we're using. We're going to address some changes to when members can disenroll from the Medicare Advantage plan. Those are the Medicare managed care plans. Changes in the rule to when members can change from one Medicare Advantage plan to another. Changes to whether certain kinds of Medicare Advantage plans can enroll to certain people and how many contracts they can have. And then after that big topic around intersecting with Medicare Advantage plans, including D-SNPs, we'll talk about some other changes in the rule that help members make plan choices, some improvements to supplemental benefits and other changes in the rule.

All right, so the final part, C and D rule. It was published April 23rd, 2024. It takes effect across time with several provisions effective January 1st, 2025. And this matches the cycle of Medicare and Medicare Advantage plans, where many times if a person makes a selection for a Medicare Advantage plan in the fall or early in the year, the effective date is if you make it in the fall, is January 1st. So that follows the new cycle of plans. It makes changes across the Medicare Advantage space, including D-SNPs, which are a type of Medicare Advantage plan. A little bit about the glossary. I'm going to go a little fast through this, but I wanted to give you a structure before we use all these terms. Dually an eligible individual is a person who has both Medicare and Medicaid. There are two types of dually eligible individuals.

One type is a partial benefit dually eligible individual. This is someone who gets help from Medicaid that helps pay for Medicare costs, like Medicare premiums or some cost sharing sometimes. They don't have full Medicaid. So once Medicare coverage runs out, Medicaid coverage doesn't come in. In different than partial benefit, the other group is full benefit dually eligible individuals. And those are folks who have full Medicaid. So once Medicare coverage runs out, Medicaid can come in and pay for things like home and community-based care, maybe dental, maybe hospital, other services. And a person who has a full benefit dually eligible person, they can also have Medicare savings programs. Those help with Medicare costs, but they're considered full benefit tools. Okay. Low income subsidy is assistance for paying for Medicare medication costs through part D. and Medicare Savings programs are a set of Medicaid programs that help pay for Medicare costs.

You can think of it as the weird name that have Medicare in the name, but it's actually a Medicaid program that helps pay for Medicare costs. And then finally, Medicare Advantage plans are a type of Medicare managed care. They're also known as Medicare Part C. Dual eligible Special Needs plans, also called D-SNPs, are Medicare Advantage plans. So they're a type of Medicare advantage plan that's available to dually eligible individuals. Dually eligible individuals do not have to be in the D-SNP, they can be in traditional Medicare, also known as fee-for-service. They can also join another non-D-SNP Medicare Advantage plan or be in a pace. And with that I'm going to return it over to Tiffany to talk about the start of our rule.

Tiffany Huyenh-...: Thank you Rachel. Hello everyone. My name is Tiffany. So I'll cover in this first section some changes to Medicare Advantage special enrollment periods. So there are some specific changes. The final rule we'll make to certain special enrollment periods. These are specific periods of times when people can make changes to their Medicare Advantage enrollment. So we'll cover that in this next section. Next slide please. First we'll go over some background before we get into some of these changes to help provide some context into the impact. So first, Medicare Advantage is a form of managed care. Medicare Advantage plans have provider networks and prior authorization requirements that can sometimes interfere with the person's access to medical care or preferred provider. So Medicare Advantage plans may not always be the right fit at all times and it will depend on a person's current medical needs or preferences. And because of this, Medicare does allow individuals to disenroll or leave a Medicare Advantage plan.

But some of the common reasons why people choose to disenroll include, access to certain medical care. Medicare Advantage plans can require members to get prior approval before providing requested healthcare services. So prior authorization is an element of Medicare advantage, and not generally used in original Medicare. So because of this, it can delay access to care or deny certain services. A person may also want to disenroll because their preferred provider is not part of the plan's network. If you join a Medicare Advantage plan, you must seek providers contracted with that plan, generally. So a person may have joined a specific plan thinking they could continue seeing their prior provider, but learn they can't do so because that provider is outside of the plan's approved network. Another reason may be poor coordination between the Medicare Advantage plan and Medicaid benefits. This can occur if the Medicare Advantage plan includes supplemental benefits that are duplicative of Medicaid, such as dental. Oftentimes in this scenario, a dually eligible individual is not necessarily receiving increased benefits, but instead is navigating an overlapping dental benefit with separate networks. This can lead to confusion and delays in care.

So all to say individuals can choose to leave their Medicare advantage plan if it does not fit their needs, but you are limited to doing so only during specific periods of time. Next slide, please. All Medicare Advantage plans cover

Medicare part A and B services. Many Medicare advantage plans also include the Part D prescription drug benefit as well. And all D-SNPs or dual eligible special needs plans include that prescription drug coverage. So for most Medicare Advantage members, their Medicare Advantage plan is also their prescription drug plan. If a person is enrolled in a Medicare Advantage plan with the prescription drug benefit, if they choose to disenroll from that plan, they're also disenrolling from their prescription drug coverage. But in contrast, people in original Medicare are in separate standalone prescription drug plans. The prescription drug plan is responsible for prescriptions only. These are often offered by private companies and some common part D standalone plans are Humana or SilverScript. Next slide please.

So Medicare allows a person to leave or disenroll from their Medicare advantage or prescription drug plan, but only during specific enrollment periods. There are three main periods when a person can make these changes. First is the annual enrollment period. That period runs every year from October 15th to December 7th. Here you can enroll into a Medicare Advantage or prescription drug plan, or disenroll from either of these plans. Any change we make during this time is effective the following year. So if you make a change on October 30th, it is affective January 1st of the following January. 2nd, there is the Medicare Advantage Open enrollment period. Here, current Medicare Advantage members can change their plan enrollment. You can switch into another Medicare Advantage plan or return to original Medicare and join a Part D plan. This runs from January to March 31st of every year. And then lastly, there are special enrollment periods. Special enrollment periods allow people to make changes mid-year and outside of these other enrollment periods, as long as you meet certain criteria.

There are several types of special enrollment periods and each have their own criteria, such as someone who becomes newly enrolled in Medicaid or someone who loses Medicaid or someone that loses their extra help or low income subsidy benefit for their prescription drug coverage. Next slide please. So today, dually eligible individuals and people with that extra help or low income subsidy have what is called the quarterly special enrollment period. With this quarterly SEP or special enrollment period, these two groups can make changes to their coverage once every three months. It can be used in two ways. First, for people that are currently enrolled in a Medicare Advantage plan, the quarterly SEP can be used to disenroll from that plan and back to original Medicare and a standalone prescription drug plan. Or you can use this special enrollment period to enroll into a different Medicare Advantage plan that has prescription drug coverage. For those that are in original or traditional Medicare, you can use this special enrollment period to join a different prescription drug plan.

So this special enrollment period still exists today, but it will be eliminated in 2025 because of the final rule introduced by the Center for Medicare and Medicaid Services. It's a federal agency that oversees the Medicare and Medicaid programs. Next slide please. So next year in 2025, that quarterly

special enrollment period is eliminated. It is no longer available. In its place CMS created a new monthly special enrollment period. This new monthly special enrollment period is also for people who are dually eligible with both Medicare and Medicaid benefits, or people who are Medicare only and have the extra help or low-income subsidy benefit. Partially, dually eligible individuals can also use this special enrollment period and changes can be made on a monthly basis. Next slide please. There are two ways people can use this new monthly special enrollment period. So first, if you're currently in Medicare Advantage, you can choose to use this special enrollment period to leave your plan if it has the prescription drug benefit and return to original Medicare by enrolling in a standalone separate prescription drug plan.

So again, for most Medicare Advantage enrollees that Medicare Advantage plan is their prescription drug benefit. So they can use this SEP to leave that plan if it's not meeting their needs, and can do so by choosing to join a separate standalone prescription drug plan. And that will return them to original Medicare. Second, people that are already in original or traditional Medicare and have that standalone prescription drug plan, they can change their prescription drug plan choice. They can do so on a monthly basis using this special enrollment period. This special enrollment period does have one exception. It cannot be used to enroll into a new Medicare Advantage plan or switch from a Medicare Advantage plan into another Medicare Advantage plan.

It's limited to changing standalone prescription drug plans or leaving Medicare Advantage and returning to original Medicare. This is a change from the prior quarterly special enrollment period. The reason for this change to the quarterly SEP and creating this new monthly one, is because of reports that it was difficult to track, that the prior quarterly special enrollment period and whether or not someone had used it in the past three months. It was also too limiting for people who needed to make coverage changes on a more frequent basis. I'll also note that all other Medicare enrollment periods that we covered are unchanged and other special enrollment periods that are available are still there today. And with that, I'll turn it over to Rachel to cover the next bit.

Rachel Gershon,...: Thanks so much, Tiffany. So next up we're going to talk about some enrollment options for changing Medicare Advantage plans. And I just wanted to put a marker in here. Tiffany just discussed options for disenrolling from Medicare Advantage plans and choosing a standalone prescription drug plan, or changing a prescription drug plan when you're in traditional Medicare. Now we're going to move on to, if you're in a Medicare Advantage plan as a dually eligible individual and you want to change plans, what are your options, and how is that changing in 2025? So in addition to disenrollment, Medicare Advantage enrollees have an opportunity to change their Medicare Advantage plans during the following periods. And this is for all Medicare Advantage enrollees, not just dually eligible. The annual enrollment period, which is in the fall and becomes effective in January. The Medicare Advantage open enrollment, which is the first

three months of the year. And then special enrollment periods that may come up from time to time.

For example, if you've moved or if other circumstances come up. And these are all delineated on CMS website that we can share with you about changing plans. One particular kind of special enrollment that exists right now is for dually eligible. So both partial and full, and LIS individuals. So individuals who have that help for Part D medications known as low-income subsidy or extra help. And they can change plans right now, once per quarter. So similar to the disenrollment that was once per quarter, this is an opportunity to change plans. The first three red bullets on this slide are not changing in 2025. So the annual enrollment period, the Medicare Advantage open enrollment period and the special enrollment periods, other than this particular dually eligible one that's talked about in bullet number four. So what is changing? There's a new integrated special enrollment period. So instead of dually eligible individuals and individuals who have LIS being able to change Medicare Advantage plans once per quarter, it's now going to be limited only to full benefit dually eligible individuals.

And they will have a chance to change Medicare Advantage plans once a month, rather than once a quarter. But there is a big asterisk here. If you're changing, you can only change into a plan that is considered integrated. And here we have a lot of new terms. So you might've heard fully integrated plan or sometimes called FIDE SNPs, highly integrated plan, sometimes called HIDE SNPs, or applicable integrated plans AIP, which other D-SNPs can be as well. And also the plan has to be aligned. Meaning that if you as an individual are trying to change into that D-SNP that is integrated, it has an affiliated Medicaid managed care organization, MCO that you are also in. So you would either need to already be in that MCO at the Medicaid level or be moving into the MCO at the same time that you're transitioning to that new D-SNP. So as you can see changing Medicare Advantage plans, the choice has narrowed somewhat both in who can do it and which plans you can change into under the specific integrated special enrollment period.

But it has also become more frequent for those folks who fit into that category. There are some exclusions to this integrated special enrollment period. So partial benefit dually enrolled individuals, so these are folks who have health paying for Medicare costs from Medicaid, but they don't have the full Medicaid coverage. They'll no longer have that quarterly special enrollment period for changing Medicare Advantage plans. And similarly, people with extra help or low-income subsidy will no longer have that SEP for changing Medicare Advantage plans every quarter. I'm going to give some examples. So first, Maria has Medicare and full Medicaid. She is a full benefit dually eligible person. Maria is in a Medicare Advantage plan with prescription coverage, but her specialist Dr. Lee is no longer in her network. So she wants to change Medicare Advantage plans to help get Dr. Lee in her network. In July of 2025 Maria wants to disenroll

from her current Medicare Advantage plan and enroll in Health first FIDE D-SNP, so fully integrated plan.

Maria can see Dr. Lee as a health first FIDE enrollee. Maria is currently in fee-for-service Medicaid. So let's think through this. First of all, is she in an open enrollment period or a special enrollment period? She's not in the annual enrollment period. That's October 15th through December 7th, I think. She's not in the January through March Medicare Advantage open enrollment period. And let's say that she's not in any other special enrollment period other than the integrated one. Okay, so she wants to try to use the integrated one. Next question. Is the plan that she's enrolling into an integrated plan? Yes, it's a FIDE SNP. FIDEs are integrated. Third question, is the plan aligned with her Medicaid managed care organization? The answer is no, because she is in fee-for-service Medicaid. But she can switch into the health first FIDE SNP, as long as she also enrolls in the Medicaid Managed Care organization at the same time.

So this is an example of how the integrated SEP might work for an individual. Example number two, let's say that Maria's only Medicaid benefit with the Medicare savings program. So she's a partial benefit dually eligible person. She can't then use the integrated SEP as a partial dually eligible individual, because it is not an option for partial benefit dually eligible individuals. She can use the annual enrollment period, the Medicare Advantage open enrollment period or another special enrollment period to switch into Medicare Advantage plans. And we go into more detail into this in the issue brief. If you have questions or if you want links, for example, to what other special enrollment periods might look like for Medicare. This is a chart that we put together to try to wrap this all up. So the quarterly SEP, which exists today in 2024, is for all dually eligible individuals and low-income subsidy recipients.

It means that a person can change MAPD plans and prescription drug plans each year. MATD is a Medicare advantage with prescription drugs coverage. So a person can disenroll from Medicare Advantage with prescription drug coverage, they can change Medicare advantage plans and they can switch to a different prescription drug plan. That is eliminated as of January 2025. There is a new monthly SEP, special enrollment period for all dually eligible and low income subsidy. So this is full duals, partial duals, low income subsidy, and it allows you to disenroll from a Medicare advantage plan with prescription drug coverage. So if you are in a Medicare Advantage plan that also has prescription drug coverage, you're able to disenroll and it allows you to enroll in a standalone prescription drug plan, an original Medicare. You can also, if you're on original Medicare, switch from one standalone prescription drug plan to another. And finally, the SEP that I just talked about for full dually eligible individuals, it's a monthly special enrollment period to enroll into certain integrated D-SNPs that also have aligned plans.

Because this is so complicated, I'm going to read through the slide for another crack at talking through all of these. So all dually eligible people and those with

LIS can disenroll from a Medicare Advantage plan that has a prescription drug coverage on a monthly basis. Full dually eligible individual people can enroll in or switch Medicare Advantage plans on a monthly basis, if they are switching into an integrated aligned plan. Partial and full dually eligible individuals can enroll in or switch a Medicare advantage plan during annual enrollment, Medicare Advantage open enrollment periods or another special enrollment period, just as any other Medicare beneficiary can. And then these changes are intended to increase enrollment into these integrated and aligned D-SNPs and limited enrollment into non-integrated Medicare Advantage plans. And with that I will turn it over to Tiffany for the next part of the rule.

Tiffany Huyenh-...: Thanks Rachel. So that last section we discussed changes to certain special enrollment periods and the new addition of the integrated special enrollment period. And now we will cover the next section, which is limits on D-SNP enrollment and contracting. So the final rule also limits the number of D-SNPs, dual eligible special needs plans that insurance companies can operate, and it places limits on who can enroll into certain D-SNPs. In this section we'll cover those changes. It is part of a broader effort by the federal government to increase the number of people who receive their Medicare and Medicaid services through the same insurance company. CMS's stated goal with some of these rules is to increase enrollment into aligned plans. D-SNPs have grown rapidly with more than... Sorry, more than 5 million people enrolled in a D-SNP. In 2024 there are 854 D-SNPs operating today. So some insurance companies can operate multiple D-SNPs in a single zip code, with little obvious difference between the provider network or benefits.

This can lead to an overwhelming number of choices for a person to navigate. So because of this, CMS has introduced some enrollment and contracting rules to simplify the number of choices on the market and to promote greater alignment between D-SNPs and Medicaid managed care plans. Next slide please. So the first change limits enrollment into certain D-SNPs and there are two parts. If an insurance company operates a D-SNP and also operates a Medicaid plan that serves an overlapping service area, new enrollment into that D-SNP will be limited. So this rule applies to D-SNPs who have affiliated Medicaid managed care plans, which generally means the D-SNP and the Medicaid plan are operated by the same parent insurance company or they have a specific contractual relationship.

So under the new rule, these D-SNPs must limit new enrollment starting January 2027. They can only accept new members who are also enrolled or in the process of enrolling into the affiliated Medicaid plan. So this means that in 2027, a full benefit dually eligible individual who wants to join a D-SNP with an affiliated Medicaid plan will not have a choice of Medicaid plan. They must enroll in the affiliated Medicaid plan of the D-SNP. And then secondly, in 2030, all members of the D-SNP must be in the affiliated Medicaid plan. The D-SNP will have to DISENROLL members who are not aligned and not enrolled in that affiliated Medicaid managed care plan. So in the years between '27 and 2030,

the D-SNP can work on aligning enrollment to prevent disruption at year 2030. Next slide please.

One back. Perfect, thank you. So the limits on D-SNP enrollment do not apply in two areas. First, it does not apply to D-SNPs that only enroll partial dually eligible individuals. Again, partial dually eligible individuals are those with Medicare and a Medicare savings program, but do not have full Medicaid. So a company could still operate a D-SNP that is limited only to partial benefit, dually eligible individuals only, regardless of whether their parent insurance company also operates a Medicaid plan. These limits also do not apply to unaligned D-SNPs. It only applies to D-SNPs that are aligned, D-SNPs that have affiliated Medicaid plan. So some D-SNP insurance companies do not operate Medicaid managed care plans. These companies can still have multiple D-SNPs in the same geographic area since they are not affiliated with any Medicaid plan.

I'll note that these type of D-SNPs, those without affiliated Medicaid plans are not considered integrated. So dually eligible individuals cannot use that new integrated special enrollment period to enroll into these plans, and they must wait for the regular enrollment period or another special enrollment period. So let's go through some examples. Jack is enrolled in a Medicaid managed care organization. In January 2027 he tries to enroll in a D-SNP that is not aligned with his current Medicaid managed care plan. The D-SNP is aligned with the affiliated Medicaid managed care organization in Jack's area, however. Can he do so? Next slide, please. Yes, Jack can join that D-SNP, but only if he changes his Medicaid managed care plan to align with that desired D-SNP. So he must change Medicaid plans and enroll in the D-SNP's affiliated Medicaid managed care plan. Next slide please.

Here is another example. Deirdre is enrolled in a Medicaid managed care organization in January 2027. Apologies, that is a typo. It's not 2017, it should be 2027. So in January 2027, she tries to enroll in a D-SNP that is not aligned with her Medicaid managed care organization, but the D-SNP that she wants to join does not also operate an affiliated Medicaid managed care plan in her area. So can she enroll in this D-SNP or can they refuse her enrollment because her current Medicaid managed care choice is not aligned with the D-SNP? Next slide please. Yes, Deirdre does not have to change Medicaid plans. Her desired D-SNP choice is not affiliated with any Medicaid plan in her area. They can enroll any dually eligible person in its service area, regardless of the Medicaid plan enrollment choice. With that, I'll turn it over to Rachel.

Rachel Gershon,...: Thanks so much Tiffany and thank you everyone for holding through this extremely complicated rule. We know there's a lot of different parts that interact in your state specifically, in different ways and we look forward to addressing some of these in the Q&A and also talking with you afterwards, as you think through what this means in your states. Okay, so Tiffany has gone through certain D-SNPs that have to limit their enrollment in the future to align enrollees full benefit. And now I'm going to talk about a different topic that's

very similar. So what happens every year is Medicare Advantage plans. The companies that run Medicare Advantage plans go to the centers for Medicare and Medicaid services, which is a federal agency and they ask permission to sell these Medicare Advantage plans in certain areas and it happens on a yearly basis, this request. And CMS has come out and said in this rule that starting in 2027 certain types of D-SNP plans, there can only be one in the area.

But it's a very specific type of D-SNP plan that I'll get into. So for D-SNP serving full benefit dually eligible individuals and who have an affiliated Medicaid managed care organization in the area, then they're generally only allowed one plan per service area in 2027. This has an exception to it. So maybe a state allows insurance companies to offer these D-SNPs to maybe one kind of D-SNP to folks under 65 and one type of D-SNP to folks over 65. That may be a case where there's an exception and the company would be allowed to offer D-SNPS for full-benefit dually eligible individuals with an affiliated Medicaid managed care plan to more than one. But that's one of the exceptions. Let's talk about this a little further because this is complicated. So companies can have multiple D-SNPs if they don't serve full-benefit dually eligible individuals. So let's say Corporation Alpha offers three D-SNP plans in an area.

One D-SNP plan is a full-benefit dually eligible with an affiliated Medicare managed care organization or Medicaid managed care organization. But the other two are for partial benefit. They're fine. They're not going to have to reduce the number of plans in the area. CMS will allow multiple D-SNPs to operate if they focus solely on partial-benefit dually eligible individuals. Companies affected by the restriction can also take steps to transition enrollees from one D-SNP to the other if they're closing. So let's say company Beta has two full-benefit dually eligible individual D-SNPs in an area that have affiliated Medicaid managed care plans and they have to reduce it to one, they will have some options for transferring folks over from the now-defunct D-SNP to the continuing operating D-SNP. All right, there's some examples. So let's say Annie is enrolled in D-SNP A in 2026. So this is before the restriction comes into place.

The company that operates her D-SNP also owns another D-SNP in the same overlapping area. Both D-SNPs serve full-benefit dually eligible individuals. The company also operates a Medicaid managed care organization in the same area. So this is checking all the boxes. What happens in 2027? There's two D-SNPs. They are both serving full-benefit dually eligible individuals. They both have an affiliated Medicaid managed care organization in the area. So in 2027, unless there's that weird state thing where you can go over 65 or under 65, what happens in 2027 is the company will only be allowed to offer one aligned D-SNP that serves full-benefit dually eligible individuals in that area. Annie will be notified of the transition to the remaining D-SNP. She can enroll in that D-SNP and align her Medicaid plan or choose another Medicare advantage plan. There are some other choices.

She could also return to original Medicare or join a PACE [inaudible 00:38:33] Another example. John has Medicare and he is a qualified Medicare beneficiary or QMB, which is a Medicaid program that helps him pay for Medicare premiums and cost sharing. He is enrolled in a D-SNP in 2026. He's heard that his D-SNPs company has to reduce the number of their D-SNPs in 2027. What happens? For John because he's a partial benefit dually eligible individual, he's likely in a D-SNP that's only serving partial benefit dually eligible individuals at this point. And the plan can continue to operate John's D-SNP and limit enrollment to only allow partial benefit dually eligible individuals. Okay, so with that, I think I'm turning it back over to Tiffany to talk about simplifying and facilitating plan choice.

Tiffany Huyenh-...: All right, thank you again Rachel. And just looking at the chat, I know there's a lot of technical terms in here and a lot of acronyms. And I think it goes to show that the D-SNP landscape, the dual eligible special needs plan landscape is large, and advocates and individuals widely report a confusing landscape with many choices and an overload of information. So the new rule does also contain changes meant to simplify choices and help individuals make more informed decisions about planned choices. Next slide please. Next slide please. Oh, perfect, thanks. So there's also some further restrictions on D-SNP look-alikes, and the final rule took steps to restrict the number of D-SNP look-alikes that are available further by lowering the threshold for identifying these D-SNP look-alike plans. As background, D-SNP look-alikes are regular Medicare advantage plans that have a high number of enrollees who are dually eligible for Medicare and Medicaid.

Unlike actual D-SNP plans, these plans that have the D-SNP designation, look-alikes do not have any obligation to coordinate Medicaid benefits for its dually eligible members. It does not have a contractual relationship with the state Medicaid agency and it is not subject to specific regulations that are intended to coordinate care and better health outcomes for dually eligible individuals. They're called look-alikes because they have a high number of dually eligible people enrolled, but they're not actually a D-SNP. So over the past several years, the federal government has limited the proliferation of these D-SNP look-alikes because they undermine efforts to encourage integration and enrollment into actual D-SNP plans. If a plan is identified as a D-SNP look-alike, CMS will not contract with the plan and that plan must end operations. So a plan that's identified as a D-SNP look-alike must transition its enrollees into other plans. It could be a D-SNP if the company operates one or a person may return to original Medicare.

Today a plan is considered a D-SNP look-alike, if 80% or more of its enrollees are dually eligible. Under the final rule that threshold will drop even further. It will drop to 70% in 2025. And then in 2026, D-SNP will be considered a look-alike if it has 60% or more members that are dually eligible. So again, this is all an effort by CMS to reduce the number of confusing choices and encourage more enrollment into more integrated products that are meant to serve people that

are dually eligible. Next slide please. There are also some changes to the Medicare Plan Finder. The Medicare Plan Finder is the online tool to help people find Medicare advantage and Part T plans in their zip code. After significant interest and comments from other advocates and others, CMS is modifying the Medicare Plan Finder to improve the experience.

So in 2025 for D-SNPs that are also applicable integrated plans to specific designation Medicare Plan Finder will indicate that both Medicare and Medicaid services are available. So today the plan Finder will only display the benefits and services provided by the Medicare D-SNP, but does not display additional benefits that may be covered through the Medicaid plan, such as vision or transportation. So the changes to the Medicare Plan Finder is meant to be helpful because it gives people a more comprehensive understanding of all the benefits that would be available to them via Medicare or Medicaid. And individuals can more accurately compare their different options. Next slide please. CMS also introduced improvements to special supplemental benefits for the chronically ill or SSBCI. These supplemental benefits for the chronically ill are a type of supplemental benefit Medicare Advantage plans can offer.

It is meant for people with chronic complex conditions and can include nonmedical services such as transportation or home modifications. These SSBCI are intended to address social factors that can affect a person's overall health and well-being, such as food insecurity or a lack of stable and safe housing. So while many Medicare Advantage plans offer these type of benefits, there are many questions as to how widely used they are, their effectiveness, and if people are being misled about their availability. The new rules are an effort to increase transparency and ensure that these special supplemental benefits for the chronically ill are evidence-based and meaningful. Next slide please. So the final rule includes some changes to these benefits to curb misleading marketing, so people don't join a Medicare Advantage plan believing that these supplemental benefits for the chronically ill are readily available. So starting this October, Medicare Advantage plans must tailor their marketing.

So it's clear that these benefits have eligibility criteria and that not everyone who signs up is guaranteed access. Plans will also have to standardize eligibility criteria and cannot change qualifications mid-year. They must demonstrate to CMS evidence-based effectiveness of a particular special supplementary benefit for their chronically ill. And lastly, Medicare Advantage plans will be required to notify members mid-year of any unused supplemental benefits that a member is likely eligible for and did not use. One note, however, is that the rule doesn't go so far as requiring plans to notify individuals of supplemental benefits that were used but not exhausted. They're only required to notify members of supplemental benefits that were never used during the year. Next slide please. We don't have time to provide details, but I'll highlight some other changes in the final rule as well. So these include new standards for network advocacy, for outpatient behavioral health services requirements that Medicare Advantage plans conduct annual health equity analysis of utilization management policies

and procedures, as well as introducing limits for out-of-network cost sharing and D-SNP preferred provider organizations for specific services beginning in 2026.

And the issue brief that we released also goes into more details of these other provisions. Next slide please. So some advocacy opportunities. The new rule brings in many changes and there is ample opportunity for advocacy here due to the overlapping and very technical late nature of many of these provisions that we covered. Advocates and counselors can take a lead role in providing accurate information as these changes roll out. Specifically with the new special enrollment periods much education is needed so that people know of these new options and their limitations. The quarterly special enrollment period has been in place for several years, and the new monthly special enrollment period will help alleviate barriers to access due to prior authorization or limited networks. But people won't be able to use these tools if they aren't aware of the new changes. This also means advocates, SHIP counselors, health plan staff, and others need to be aware of the new changes and where to direct people for accurate information.

Advocates should also look out for unintended consequences of the final rule. One example, our Medicaid managed care locking periods. Some states limit when a person can change their Medicaid managed care plan choice. Some states allow changes year-round, others only during limited windows. So combined the final rule that requires Medicaid managed care and alignment to enroll into an integrated D-SNP, individuals may have limited opportunities to change plans. So advocates can work here to push their states to align their Medicaid managed care enrollment periods to coordinate with those for Medicare Advantage plans. Second, the changes to the Medicare plan finder are overall positive, but it could be misleading to some dually eligible individuals who are not part of Medicaid managed care. The Medicare Plan Finder that displays Medicaid services for certain D-SNPs may not be an option for those individuals not in Medicaid managed care. And again, much of the info we cover today also requires knowledge of the type of D-SNP a person is enrolled in, whether it is a HIDE, highly integrated dual eligible plan, applicable, integrated, a lot of acronyms, but the Medicare Plan Finder does not yet account for these needs.

And so there's still an area with room for improvement for a better experience and continued advocacy is needed to push for these changes. Next slide please. So on this slide we do have several resources available. Our issue brief is now live. We have our D-SNP basics brief that we released earlier this year. That brief goes into definitions about dual eligible, special needs plan, integration requirements. It covers a lot of the acronyms that we provide today, so that's a good companion paper to read alongside our issue brief on the new changes. And then we also listed some other analyses and of course, SHIPs or State Health Insurance Assistance Programs have counselors that are also versed in

many questions about D-SNPs. And with that, we can turn it over to questions from the Q&A.

Rachel Gershon,...: Absolutely. Thank you so much, Tiffany. So I've looked through your wonderful set of questions, everyone. Thank you. I'm going to start with a hard one and I'll answer it to the best of my ability, about an individual who was pressured into another Medicare Advantage plan with a prescription drug coverage that doesn't meet their formulary needs for prescription drugs. And formally they were in a group that could switch to another MAPD during the quarterly SEP and now they wouldn't be covered. And that is a hard situation. I will say, to check the other enrollment periods including special enrollment period. And I would want to note that disenrollment from an MAPD is still allowed. It's allowed on a monthly basis, where a person would go back to traditional Medicare and then be able to select a prescription drug plan as well. And that might get the person the medication that they need on the formulary.

It may have some drawbacks, where they may lose some supplemental benefits from the Medicare Advantage plan. If they're a dually eligible person, I will note that if they have full Medicaid, a lot of the supplemental benefits offered by Medicare Advantage may be duplicative of what they would get from Medicaid. So this is a very individual circumstances, but I wanted to talk through the things to think about when approaching these kinds of questions. The next question I got asked a lot was around spend down and how that intersects with being able to stay on a D-SNP. Tiffany, do you want to address spend down folks and how they're considered and what deeming looks like, or would you like me to? I'm happy either way.

Tiffany Huyenh-...: I can. Spend down people on spend down Medicaid. It's also referred to as medically needy Medicaid, or in some states share of cost Medicaid. But essentially it's people that are over income for the free Medicaid aged and disabled or program in their state. They're basically given a quasi deductible, but they can spend some money out of pocket on healthcare expenses to qualify for full Medicaid. But essentially, they do have an out-of-pocket cost, it's not free to them for these individuals. They may be allowed to join a dual eligible special needs plan. If they meet their spend down in the month, their Medicaid becomes active and they're in the D-SNPs. But some D-SNPs do not allow these groups of people to join their plan. So someone that may have been on full Medicaid and then because of a Medicaid renewal is moved to spend down Medicaid, may no longer qualify for enrollment into the D-SNP because they no longer have full Medicaid.

Many D-SNPs offer a deeming period, which is essentially a grace period, where people can try and fix their Medicaid eligibility so that they can retain enrollment. But it is very specific by state. So I do encourage folks that are having or seeing problems with folks on Medicaid spend downs, and are losing their D-SNP enrollment, is to ask if the D-SNP has a deeming policy. And if they don't, you can also work with your states to try and encourage the states to

require that D-SNPs have this deeming period because it can be very helpful. It helps preserve access to care and prevent disruption as well.

Rachel Gershon,...: Thanks so much Tiffany. And I'm going to take the next set of questions that are asking, how do we know, right? How do we know that a plan is aligned, that it's integrated? Because now all of a sudden the fact that a plan is aligned and integrated, it's very important for knowing whether a person is going to be able to take advantage of this monthly special enrollment period to change plans. I will note, it's not as important if you just want to disenroll and go to traditional Medicare and get a prescription drug plan, but that's not the best choice for everyone. So if you want to change into another Medicare Advantage plan, you're outside of other enrollment periods, how do you figure out that a plan is aligned and integrated? I will say that right now it's not that easy. I do have some methods for finding out, at least for integrated.

So integrated is going to look like they're either going to have a FIDE, a HIDE or an AIP designation. And the way, honestly, that I find out is I go to a website about CMS SNP data, special needs plan data. I download the Excel document for the state and I look up the plan name and plan number, which is also available in Medicare Plan Finder. So you can figure it out. But this is not a typical Medicare enrollee. This is maybe a SHIP counselor who wants to get on top of which plans are going to be integrated in the next year, so they can understand how this intersects. And if you have more questions about that process, we do talk about it in our D-SNP basics brief that is on this slide in the appendix. It gives you the link to find that Excel document. Not friendly to the regular Medicare beneficiary, but it is there.

In addition, CMS is thinking about putting the HIDE, FIDE AIP designation in Plan Finder, but they're hesitant to add too many complicated terms to Plan Finder to make it as user-friendly as possible. Which is a typical struggle in Medicare to make sure that people have access to accessible, easily understandable information, but also understanding this very complex program. The question of alignment, how do you know which Medicaid managed care organizations are aligned, is a really tough one. And it's one that we've asked CMS to release a list. There is a list available of all default enrollment Medicare plans, which in order to be default enrolled, you need to have an aligned Medicaid managed care organization or Medicare managed care plan. But it doesn't give you the list of which Medicaid managed care plans there are. There is a question that came up that asked to talk a little bit more Tiffany, about the low income subsidy. What is that? What is extra help? If you could answer that, that would be great. And then Tiffany, if you find questions that you want to answer, please, please feel free to add those onto that.

Tiffany Huyenh-...: Yeah. Low income subsidy or extra help, it is a federal program. It's different than a Medicare savings program. Low income subsidy or extra help is a federal program that provides financial assistance for Medicare Part D prescription drug costs, can help with the co-pays to limit the copays, co-insurance, the

deductibles, as well as it provides the premium payment for certain Part D prescription drug plans. Anyone that has Medicaid, whether it be full Medicaid or if they're on a Medicare savings program, or if they receive supplemental security income, automatically get extra help. There's no separate application, they're just given extra help. Other people can apply for it. And the income limit is 150% federal poverty level. But the monthly special enrollment period that we discussed could apply to people who only have that low income subsidy and it gives them the opportunity to change their prescription drug plans. And just one question, or multiple questions, I think in the Q&A asked about what does integration or integrated and what does aligned mean?

I do encourage folks to read the basics brief because it gives a much more deeper definition, but I'll try and do it quickly. But integrated are dual eligible special needs plans that, because of how they deliver or structure the Medicaid benefits are subject to higher requirements by the federal government. They have to coordinate care. They may have unified appeals and grievances, but it's considered a plan that coordinates the Medicare and Medicaid benefits on a higher level, compared to other D-SNPs that are not considered integrated. Aligned plans would mean, essentially, an example that I give quite often is that someone is enrolled in a Medicare plan that matches their Medicaid plan. One example is, company ABC operates a D-SNP and they operate a Medicaid plan. A person is considered to be an aligned enrollment if they're enrolled in company ABC's D-SNP and company ABC's Medicaid plan. There is one insurance organization that has the administrative and financial incentive over both the Medicare and Medicaid benefits. But I think our brief goes into much more detail on a very complicated and technical question.

Rachel Gershon,...: Thanks so much, Tiffany. We're getting a lot of notes that this is really complicated and I very much agree. There's a lot of terms, there's a lot of intersecting thoughts. One thing that we're really keeping an eye out for is, if you are in a state where dually eligible individuals are in Medicaid MCOs and they're locked in for a certain period, so they're only allowed to change MCOs during a certain period of time, we have our antenna raised about how that's going to intersect with these newer rules for when you can change Medicare Advantage plans. So for example, even that specific circumstance where you can change into a D-SNP that is aligned and integrated. What does that mean if you can't change your Medicaid plan at the same time to become aligned? So if you're seeing challenges with that in your state, we definitely want to hear about it. And just in general, with implementation we want to hear about challenges you're seeing.

I will say, in terms of addressing terms and how to talk to the person in front of you, who's trying to make a plan choice or trying to get out of a plan or change a plan, highly recommend our D-SNP FAQ. We went through the questions, thinking through having a person in front of you trying to make plan choices and figure out what their choices are in different circumstances. And that D-SNP FAQ is updated to include changes from this final rule. So we make note of how

things are changing in 2025, 2027, 2030. So that is my answer there. Tiffany, do... Oh, and then there was one more, and then I might pass it to you, Tiffany, if you're seeing anything. Somebody asked, how can we get help for individuals who are having trouble with these choices? Highly recommend State Health Insurance Assistance Programs, known as the SHIPs. They're federally funded, every state has them. You can find them by going to shiphelp.org and looking through your state. So the SHIPs, S-H-I-P, they're Medicare advisors that can help think through these issues as people are dealing with Medicare managed care.

Tiffany Huyenh-...: I don't have other... Well, there's a lot of questions in there. I know we're over time, so I just want to-

Rachel Gershon,...: Oh, are we? I have not [inaudible 01:03:50] Oh, we are, I'm sorry. My apologies.

Tiffany Huyenh-...: No worries. Just want to let everyone know. Thank you for attending. Really appreciate it. And for holding through with us through this complicated presentation. The issue brief is live. I know it's in the chat. We do get your questions that you've asked and we can follow up after through email. So Rachel and I will be going through and answering you as well. So really appreciate everyone's engagement and patience with us during this webinar.