Special Needs Plan Alliance

Final Rule Provisions

1. **Lookalikes** – Percent of dual eligible enrollment at which point a non-SNP MA plan is considered a "lookalike," from 80% currently to 70% in 2025 and 60% in 2026.

2. **Service Area** – CMS is limiting MAOs to offering a single D-SNP in the same service area as the organization's Medicaid MCO serving full benefit dual eligible individuals.

3. **SSBCI Bibliography** – CMS is requiring plans offering SSBCI to create a bibliography with evidence from, at a minimum, the past 10 years that demonstrates reasonable expectation of improving/maintaining the health or overall function.

4. **Supplemental Benefits** – For all supplemental benefits, CMS is requiring MAOs to notify members mid-year of the unused supplemental benefits available to them.

5. **I-SNPs** – CMS finalized two new exceptions from network adequacy requirements for facility-based I-SNP plans operating on a single contract ID.

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Final Rule Provisions, Cont…

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Special Election Periods – CMS replaced the current quarterly dual eligible SEP with two new monthly SEPs: 1) duals moving to standalone PDP and 2) full duals moving to integrated D-SNP

7

C-SNPs – Clinicians able certify eligibility includes NP broadened from Physicians only, new MOC requirements, additional conditions, and a definition of C-SNPs.

8

Health Equity – Includes an array of changes impacting utilization management (UM) and health equity index (HEI).

9

Operational Requirements – Also includes an array of provisions with probable increased overhead requirements including additional in-network BH provider types, Agent/Broker Requirements, additional reporting requirements.

10

Model of Care—CMS codifies and clarifies current practice and processes for SNPs regarding submission, review, and approval of their MOC, specifically clarifying the off-cycle submission policy.

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2025 Themes	2026 Outlook
Implementation of Unused Statutory Provisions, Codification of Historical Practice and Increase CMS Regulation of Plans -- In 2025, CMS utilized an array of statutory provisions in the ACA, BBA and BIPPA it had not yet leveraged. These include bid denial based upon insufficient data or provisions CMS deems unclear or failing to meet its requirements on a case by case basis, and SSBCI evidence requirements. Additionally, the rule includes a brief paragraph on CMS' authority to collect any data it deems necessary for plan oversight. While brief, this ACA authority has sweeping implications for the plan sector in terms of administrative requirements and oversight. The Final Rule also codifies an array of CMS historical practices. Regarding impacts on SNPs, the new requirements will result in notable internal operational changes and highly probable increased operating overhead. These increased overhead costs must be coupled with the impacts of the final Rate Notice and SNP capacity to meet beneficiary needs as well as be innovative and nimble in this regard.	**Continued Use of Statutory Authority, Enforcement of Past Rulemaking, and Election Uncertainties** – In keeping with CMS' trend toward increased plan oversight and regulation, the SNP Alliance anticipates continued implementation of here to fore unused stator authority across MA and SNP statutory authority and, finalization of past proposed rulemaking which are now CMS priorities, and codification of historical practice. The SNP Alliance will be exploring these possibilities through review of materials and dialogue with CMS. From there, the Alliance will assign ranking – possible but not probable, probable, highly probable. The Presidential election creates uncertainty. A second Biden term likely would continue the above with an early NPRM release to implement as many possible additional MA and SNPN policy priorities as possible. A second Trump Administration likely would result in a later NPRM release to allow the Administration to have some input on the 2026 rule. If the latter, any significant changes would occur in the 2027 rule with a high probability of reversing Biden policy.

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Final Summary Rule	SNP Alliance Comments	SNP Alliance Impact on Rule	SNP Alliance Action Steps	Implementation Timeline/Deadline
Integration Provisions				
Monthly SEP: Replace the current quarterly special enrollment period (SEP) with a one-time-per month SEP for dually eligible individuals and other LIS eligible individuals to elect a standalone PDP.	Generally supported.	Commentors were very split on this topic. SNPA comments were similar to others who generally supported this direction.	SNP Alliance will identify a small group of D-SNPs to collect data on this provision as well as others. For this provision information will be collected on churn and shared with CMS during monthly meetings. **Lead Work Group: MMI**	Finalized without modifications effective 1/1/2025.
Integrated Care SEP: Creates a new integrated care SEP to allow dually eligible individuals to elect an integrated DSNP on a monthly basis which would allow enrollment in any month into FIDE SNPs, HIDE SNPs, and AIPs for those dually eligible individuals who meet the qualifications for such plans. Dually eligible and other LIS-eligible individuals, like other Medicare beneficiaries, would be able to enroll into	Generally supported but expressed concern for restrictions on partial duals so requested partial duals to also be allowed an integrated SEP for enrollment in a CO-DSNP and requested monitoring for unanticipated consequences.	CMS narrowed the scope of the new SEP and indicated they would monitor many aspects of implementation. They did not adopt our request for integrated SEP for partial duals but did discuss the value of CO-DSNPs for partial duals in several other sections of the rule.	Offer technical assistance including how to manage different enrollment/SEP effective dates and contracting scenarios that states and plans may anticipate. **Lead Work Group: MMI**	Finalized with modifications. Narrowed scope so that this SEP is available only to facilitate aligned enrollment and is only available for full benefit dual eligible individuals effective 1/1/2025.

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non-AIP coordination-only D-SNPs or other MA plans only during the ICEP, AEP, or where another SEP permits.				
Enrollment Limitations (for enrollment alignment) Beginning in plan CY year 2027, when an MA organization, its parent organization, or an entity that shares a parent organization with the MA organization, also contracts with a State as a Medicaid MCO that enrolls dually eligible individuals in the same service area, D-SNPs offered by the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization, must limit new enrollment to individuals enrolled in (or in the process of enrolling in) the D-SNP's affiliated Medicaid MCO. This provision will initially apply to new enrollments (including those in FIDE and HIDE SNPs) and will not require the D-SNP to disenroll previously enrolled individuals (whether	General support for the concept, but we articulated a long list of concerns and questions about how the enrollment processes would work including whether Medicare or Medicaid enrollment is the primary driver and how it will work in states with auto-assignment or mandatory enrollment.	CMS made a slight modification and discussed the concerns but still did not provide clarity on the enrollment and disenrollment processes.	SNPA will raise questions to be included in the requested additional detailed enrollment guidance for states and plans and offer technical assistance including how to manage different enrollment and contracting scenarios that states and plans may anticipate. **Lead Work Group: MMI**	Finalized with a modification to clarify that any DSNP(s) subject to enrollment limitations may only enroll (or continue coverage of people already enrolled or in the process of enrolling in) the Medicaid MCO beginning in 2030.

partial-benefit dually eligible individuals or full benefit dually enrolled individuals who are not also enrolled in the affiliated MCO. Beginning in CY 2030 these integrated D-SNPs would be required to disenroll individuals who are not enrolled in both the DSNP and Medicaid MCO offered under the same parent organization. D-SNPs would still be able to use a period of deemed continued eligibility to retain enrollees who temporarily lost Medicaid coverage.				
Single Plan: Limits the number of D-SNPs an MA organization, its parent organization, or an entity that shares a parent organization with the MA organization, can offer in the same service area (including partial overlaps) as an affiliated Medicaid MCO in order to reduce "choice overload" of D-SNP options in certain markets with certain exceptions	SNPA generally supported this approach, with the caveats noted regarding enrollment as outlined above and additional concerns about interactions and unintended consequences arising from state procurement changes and local market dynamics that might result in	CMS made some clarifying statements but did not fully address the complications that can arise from these changes.	May cause temporary disruption for beneficiaries and complications for state procurement. Impacts likely to be state and local market specific. SNPA will make recommendations to ICRC for technical assistance after discussing needs with a	Finalized with modifications allowing these D-SNPs to offer more than one D-SNP for full-benefit dual eligible individuals in the same service area as that MA organization's affiliated Medicaid MCO only when a SMAC requires it in order to "differentiate enrollment into D-SNPs

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	disruptions for beneficiaries and complications for states.		sample of 3-4 State Integration Leads. Recommended State Possibilities include CA, IN, MA, MN, IN, VA, and WA State **Lead Work Group: MMI**	by age group or to align enrollment in each D-SNP with the eligibility criteria or benefit design used in the State's Medicaid managed care program(s)". Further CMS statements clarify that this could include CO-DSNPs enrolling partial dual eligible individuals if allowed by the SMAC. Effective 2027.
Look Alike Plans: CMS adopts their look alike proposal to terminate certain contracts that exceed 70% enrollment of dually eligible individuals in 2025 and 60% in 2026 and subsequent years without modification, but clarifies that the existing contracting limitations on D-SNP look-alikes at § 422.514(d) only apply in any State where there is a D-SNP or any other plan authorized by CMS to exclusively enroll individuals entitled to Medicaid, such as an MMP. Starting in 2027 and for future years,	SNPA supported the CMS provision, though it would have preferred an even lower level of 50%. SNPA also requested CMS to require states to contract with CO-DSNPs to serve partial duals in order to assure they have access to MOCs and supplemental benefits designed to meet their needs which are not available in non-SNP MA-PDs.	CMS indicated they do not have authority to require states to contract with DSNPs, but appreciated the SNPA comment on encouraging states to provide contracts to serve partial duals and said they would provide Technical Assistance to states. CMS provided information about the massive growth of look-alike MA plans. Even at the limits proposed, additional growth of lookalike plans will occur creating	SNPA will provide concrete, research-based rationales for CMS/ICRC to work with states DSNP contracts for partial dual enrollees so that these individuals have equal access to MOCs and supplemental benefits as other dually eligible individuals. **Lead Work Group: MMI**	Applies to MA plans with 70% enrollment of dually eligible individuals in 2025 and 60% in 2026 and beyond.

transitions for both full and partial dually eligible individuals in these look alike plans will be limited to D-SNPs.		additional competition for enrollments. ..		
PPO DSNP Limits and Cost Sharing: Limits out of network cost sharing for MA organizations offering a local PPO plan or regional PPO plan that is a dual eligible special needs plan. An MA organization, its parent organization, or another MA organization that shares a parent organization with the MA organization may offer (or continue to offer) both the HMO and PPO D-SNPs only if they no longer accept new full-benefit dually eligible enrollees in the same service area as the D-SNP affected by the new regulations.	SNPA supported this provision.	There was wide support for the cost sharing change among commentors.	There may be some decrease in enrollments and thus availability of PPO D-SNPs. **Lead Work Group: MMI**	Effective 1/1/26.

Final Summary Rule	SNP Alliance Comments	SNP Alliance Impact on Rule	Possible Implications on SNPs	Implementation Timeline/Deadline
Health Equity				
Health Equity *– Utilization Management* CMS finalizes	SNPA provided comments with suggestions for easing into this annual	No, we did not.	CMS dismissed the idea of an extension – all MA plans must put a	The MAO must make the results of the analysis publicly available on its

requirements around an annual Health Equity analysis of utilization management policies and procedures, through the UM Committee with expertise in health equity § 422.122(c), § 422.137 § 422.137(d)(6)	review, particularly around the timing for reporting on plan's websites.		process/method in place for tracking these metrics and reporting. This is especially significant as this is at the plan (PBP) level, not the H# contract level.	website by July 1, 2025.
Health Equity *– Health Equity Index – Part C & D Quality/Star Ratings* (§§ 422.166(f)(3) and 423.186(f)(3)— CMS sets policy for calculation of the HEI in contract consolidation.	We did not comment on contract consolidation policy pertaining to the HEI.		As SNPs review their HEI simulation reports from CMS for each H# contract, they may decide to consolidate or split contracts to meet the eligibility threshold in order to access the HEI which will be important starting MY 2025 for Stars 2027.	This is effective for MY 2025.
Special Supplemental Benefits for the Chronically Ill (SSBCI)				
Bibliography MA organizations will be required to have bibliographies for each SSBCI included in their bid to demonstrate that an SSBCI has a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee.	The SNP Alliance suggests that CMS serve as the repository of evidence for use by all plans Rather than having every health plan create a similar bibliography, it would be far more efficient to have one list maintained at the national level that is updated periodically.	No—CMS did not adopt any of our suggestions	SNPA will discuss with membership developing a repository of bibliographies at the SNPA website. With member approval, SNPA will move forward with development. **Lead Work Group(s): Leadership Policy/PE**	Must be in bids for coverage year starting January 1, 2025.

Mid-Year Enrollee Notification of Available Supplemental Benefits MAOs must provide a mid-year notice to beneficiaries about benefits used/available	The SNP Alliance is concerned that operationalizing this proposal will lead to plans moving away from person-centered benefits which is a crucial aspect of special needs plans. Knowing who was an acceptable candidate, was offered the benefit, and then refused would be very difficult. Finding these individuals who could have benefited and have not yet used the benefit to inform them of its availability—would be a substantial undertaking.	No—CMS did not adopt any of our suggestions	SNPA will convene a round table of members to develop a model RFP or Task Order format for IT contracts. **Lead Work Group(s): Leadership Policy/PE**	Implementation by January 2026.
Marketing and Communications Requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI) MAOs must use a disclaimer on the eligibility parameters for using the benefits. The SSBCI disclaimer is model content, so each MA	The SNP Alliance encourages CMS to provide guidance for a universal statement and on how to tailor specific additional disclaimer.	Yes—CMS did adopt our suggestion of a universal or model statement; however, they allow for MA organizations to modify the content.	There are serious implications for SNPs. CMS will be routinely monitoring MA accounts and auditing SSBCI disclaimer use. If MA organizations fails to comply with the disclaimer use for SSBCIs, CMS has the authority to impose financial	The new SSBCI disclaimer requirements, as finalized here, will apply to all contract year 2025 marketing and communications beginning October 1, 2024, and in subsequent years.

organization may tailor their disclaimer's language to convey that, in addition to having an eligible chronic condition, the enrollee must also meet other eligibility requirements (i.e., the definition of a "chronically ill enrollee" and the coverage criteria of the MA organization for a specific SSBCI item or service) to receive the SSBCI. If an ad mentions an SSBCI without the required disclaimer, then it is out of compliance with CMS rules.			penalties, marketing and enrollment sanctions, or contract terminations against MA organizations whose non-compliance meets certain statutory thresholds. SNPA will work with members to assess the consistency of CMS penalties and provide feedback to CMS on inconsistencies or overly onerous sanctions emerge – if any. **Lead Work Group(s): Leadership Policy/PE**	

Final Summary Rule	SNP Alliance Comments	SNP Alliance Impact on Rule	Possible Implications on SNPs	Implementation Timeline/Deadline
Chronic Special Needs Plans (C-SNPs)				
Annual C-SNP MOC submissions as required by the BBA of 2018; CMS to codify at § 422.107(f)(3)(iii)(A) the requirement, from section 1859(f)(5)(B) of the Act, that C-SNP MOCs are annually reviewed and annual re-evaluation and approval processes.	The SNP Alliance opposed this prior to it being proposed and passed in BBA 2018.	We have discussed this in comments prior to passage. It would require legislative action to remove the annual review for CSNPs.	Assess C-SNP work group views on this and identify any possible SNPA technical assistance. This would be difficult to argue with CMS because it has been historical practice and little is on record arguing against. MOCs are only approved for	This is currently in place, not change only codification of rule.

			one year for C-SNPs. **Lead Work Group: C-SNP**	
Codification of Model of Care (MOC) Scoring Requirements for Special Needs Plans (SNPs) (§ 422.101(f)(3)(iii)) ***Off-Cycle MOC Submissions for D-SNPs and I-SNPs*** CMS clarifies and codifies existing operational practices for MOC off-cycle submissions, particularly focusing on the definition of substantive changes.	The SNP Alliance has called for clarification on the CMS policy and definitions around MOC off-cycle submissions.	CMS responded to SNP Alliance request for clarification.	D-SNPs and I-SNPs are allowed to access the off-cycle submission process and this language clarifies when they should do so. There are nuances which will be important regarding substantive and non-substantive changes to MOC, off-cycle review processes, CMS ability to review even in the "closed window," and other requirements around changing care management practices following MOC approval.	This is currently in place, not change only codification of rule.
C-SNP Off-Cycle MOC submissions We proposed under § 422.101(f)(3)(iv)(F) to codify existing operational practices with respect to off-cycle submissions by C-SNPs "C-SNPs are only permitted to submit an off-cycle MOC submission when CMS requires an off-cycle submission to ensure compliance with applicable law."	The SNP Alliance opposed this prior to it being proposed and passed in BBA 2018.	Ibid	C-SNPs are prohibited from submitting an off-cycle MOC submission except when CMS requires an off-cycle submission to ensure compliance with the applicable regulations. Otherwise, C-SNPs must wait until the annual MOC submission period to make changes to their MOC. Same SNPA action steps as above.	This is currently in place, not change only codification of rule.

			Lead Work Group: C-SNP	
Expanded list of chronic conditions CMS proposed to codify the list of chronic conditions created as part of the definition of severe or disabling chronic condition at § 422.2	The SNP Alliance believes that proposed list of chronic conditions for C-SNPs would be permitted to create benefit packages and care coordination services to address the needs of beneficiaries who share the same functional needs even if their specific disease or chronic condition may differ.	Did we suggest this? Is it good? The discussion at left sounds that way.	Similar to the above, SNPA will work with the C-SNP work group to identify opportunities/challenges to creating specific care coordination services and benefit packages to address shared functional challenges facing beneficiaries. **Lead Work Group: C-SNP**	The effective date of this rule and be applicable beginning January 1, 2025. C-SNPs will not be able to effectively use this new definition to offer new C-SNPs until CY 2026 coverage,
Defining C-SNPs Adopting a definition of C-SNP in § 422.2 will help to clarify how C-SNP specific requirements—including how they are limited to serving special needs individuals who have a severe or disabling chronic condition—and policies are distinguishable from requirements and policies for D-SNPs and I-SNPs as well as different from general MA coordinated care plans.			Removed the C-SNP plan application option that is currently available under sub-regulatory guidance in section 20.1.3.2 of Chapter 16B of the MMCM beginning 2025. **Lead Work Group: C-SNP**	
Use of "physician" as provider verifying eligibility § 422.52(f) provides that each MA SNP must employ a process	The SNP Alliance supports the verification of eligibility for C-SNP	Yes—CMS did adopt any of our suggestions	In today's care settings, nurse practitioners and physicians' assistants are beneficiary's primary care providers not	The provisions we are finalizing at § 422.52(f) regarding eligibility verification for C-SNP

approved by CMS to verify the eligibility of each individual enrolling in the SNP. CMS proposed in new § 422.52(f)(1) to codify existing guidance stating that for enrollments into a C-SNP, the MA organization must contact the individual applicant's current physician to confirm that the enrollee has the specific severe or disabling chronic condition(s). we are modifying § 422.52(f)(1) to replace the term "physician" with language describing the three types of health care providers we believe are appropriate to furnish confirmation that an enrollee has a severe or disabling chronic condition: (1) a physician, as defined in section 1861(r)(1) of the Act; (2) a physician assistant, as defined in section 1861(aa)(5)(A) of the Act and who meets the qualifications specified in § 410.74(c); or (3) a nurse practitioner, as defined in section 1861(aa)(5)(A) of the Act and who meets the qualifications specified in § 410.75(b)(1)(i) and (ii). The modification will permit physician assistants and nurse practitioners who meet the specified	enrollment, but we are concerned about the language in the proposal "physician." By limiting the language to "physician" only, there is the possibility of increasing burden on physician. The SNP Alliance suggests expanding the language to include provider.		physicians. Most C-SNP beneficiaries living with a chronic condition have their conditions managed by primary care providers, not specialists. Creating a finite language around who can verify eligibility may cause denials and delays in coverage and services. **Lead Work Group: C-SNP**	enrollees are applicable with coverage beginning January 1, 2025.

qualification to provide the type of verification required under § 422.52(f). Replacing "physician" with "health care provider" or "health care provider specified in paragraph (f)(1)."				
Final Summary Rule	**SNP Alliance Comments**	**SNP Alliance Impact on Rule**	**Possible Implications on SNPs**	**Implementation Timeline/Deadline**
Institutional Special Needs Plans (I-SNPs)				
Clarified definition of institutionalized for purposes of defining eligibility for open enrollment. Included "subject to CMS approval, a facility that is not explicitly listed as part of the definition of institutionalized: but 1)furnishes similar long term care, healthcare services that are covered under Medicare Part A, Medicare Part B AND 2) its residents have similar needs and healthcare status as residents of one or more facilities listed in the definition of institutionalized.		This was a new entry and not previously in proposed rules.	Clarifies/codifies that open enrollment periods apply to additional populations with CMS approval. Unclear if this definition extends beyond open enrollment and, if so, should these members be included in FI-SNPs instead of IE or HI SNPs? SNP Alliance has scheduled a meeting with CMS to explore these and other questions and will make suggestions for clarifications. **Lead Work Group: I-SNP**	Not clear how it could be included in the application process for 2025.
Codifying new definitions for I-	SNP Alliance had no	We supported	Allows for access to additional	

SNP plans Creating three classifications of I-SNP: 1. *Facility based institutional special needs plan (FI-SNP)* all members reside in institutional settings 2. *Hybrid institutional special needs plans (HI-SNP)* includes members in institutional settings as well as those residing in their own homes and meeting a nursing facility level of care. 3. *Institutional Equivalent Special Needs Plan (IE-SNP)* members meet nursing facility level of care but reside in community settings	issues with clarifying and expanding the definitions of I-SNP considering it facilitated the ability to access additional options for meeting network adequacy		options for meeting network adequacy. SNP Alliance has scheduled a meeting with CMS to explore these and other questions and will make suggestions for clarifications. **Lead Work Group: I-SNP**	
Codification of requirements that models of care for I-SNPs ensure that contracts with long term care providers include provisions for allowing I-SNP clinical care coordination staff access to enrollees of the I-SNP who are institutionalized.	n/a		Assist in providing access to members in institutionalized settings. SNP Alliance has scheduled a meeting with CMS to explore these and other questions and will make suggestions for clarifications. **Lead Work Group: I-SNP**	
Establish additional exception to current CMS **network adequacy requirements** Specific to FI-SNPs, will not be required to meet the current two	Supported the goal of right sizing network adequacy requirements for I-SNP.	SNP Alliance has been a strong proponent of this issue and one of the original organizations raising concern and	SNPA will develop a data collection approach to identify any challenges with using the current CMS policy. If problems are documented, SNPA will	

prerequisites to request and exception from the network adequacy requirements but must meet alternates bases on with to request and exception. 1. New bases on which only FI-SNPs may request exception from NE requirements 2. Additional considerations for CMS when deciding whether to approve an exception 3. New contract term for FI-SNPs that receive the exception Limited to CONTRACTs that only include FI-SNPs May request exceptions when one of two situations occur: 1. Unable to contract with certain specialty types because of the way enrollees in FI-SNPs receive care. Decision will be based on FI-SNPs ability to submit evidence of inability to contract with certain specialty types. 2. Must meet two criteria: a. provides sufficient and adequate access to basic benefits through additional telehealth benefits when using telehealth providers of the specialists listed in paragraph (d)(5) in place of in person providers to fulfill NA standards	Expressed concerns around: 1. Only FI-SNP under contract number 2. Evidence needed to support exception - obtaining written provider documentation	providing comments over the years. CMS did not respond to concerns around 1 & 2 and moved forward as proposed.	propose changes to CMS. SNPs that combine FI-SNPs and other products under one contract number will have to create a new contract number with only FI-SNPs if they want to use the network adequacy exceptions. When building networks plans will need to capture provider refusals in a way that they can be provided during the exception process. SNP Alliance has scheduled a meeting with CMS to explore these and other questions and will make suggestions for clarifications. **Lead Work Group: I-SNP**	

AND b. substantial and credible evidence that sufficient and adequate access to basic benefits is provided to enrollees using additional telehealth benefits furnished by providers and the FI-SNPs cover out of network services furnished by a provider in person when requested by the enrollee with in-network cost sharing for enrollee.				
Open Enrollment Period for Institutionalized Individuals Codified guidance that defines when OEPI ends, which is the last day of the second month after the month the individual ceases to reside in one of the long-term care facilities described in the definition of "institutionalized."	n/a	n/a	SNP Alliance has scheduled a meeting with CMS to explore these and other questions and will make suggestions for clarifications. **Lead Work Group: I-SNP**	