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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: May 23, 2011

TO: All Medicare Advantage Organizations

FROM: Danielle R. Moon, J.D., M.P.A.
Director

SUBJECT: Issuance of new Chapter 16b (Special Needs Plans) of the *Medicare Managed Care Manual*

Included with this memorandum is Chapter 16b, a new chapter in the *Medicare Managed Care Manual* that provides guidance specific to Medicare Advantage (MA) special needs plans (SNPs). The chapter, which is part of Publication 100-16, will also be accessible online with the other chapters of the *Medicare Managed Care Manual* at http://www.cms.hhs.gov/Manuals/IOM. We issued a draft of Chapter 16b for public comment on March 3, 2011, and received 410 comments from 46 organizations during the public comment period. We considered those comments carefully as we finalized Chapter 16b. Chapter 16b also incorporates guidance from the Contract Year 2012 Rate Announcement and Final Call Letter, as well as the Contract Year Parts C and D final rule (76 FR 21432 - 21577) issued in April 2011.

Below, we summarize the major difference between the draft and final versions of Chapter 16b:

- **Definition of Fully Integrated Dual Eligible (FIDE) SNPs (Section 20.2.5).** We include an updated definition of a FIDE SNP, as described in 42 CFR §422.2;

- **Process Description and Model of Care (MOC) Scoring Criteria for National Committee on Quality Assurance (NCQA) SNP Approvals (Section 40.2 and Appendix 1).** We provide a detailed description of the NCQA SNP approval process including, but not limited to, components of the SNP approval process specific timeframes for approval, and opportunities for SNPs to cure their MOCs. We also include the specific MOC evaluation scoring criteria in Appendix 1;

- **Involuntary Disenrollment of Ineligible and Disproportionate Share SNP Enrollees (Section 60.2).** We reference guidance on the transition and disenrollment process, effective CY 2012, for ineligible and disproportionate share SNP enrollees who are ineligible to remain enrolled in SNPs as of January 1, 2010;

- **Transitioning Enrollees from Renewing and Non-Renewing Dual Eligible SNPs (D-SNPs (Section 60.3).** We provide an overview of CMS policy for D-SNP renewals and non-renewals in certain circumstances including, but not limited to, renewal options for a D-SNP with no State contract consolidating with a D-SNP with a State contract, renewal

options for a D-SNP that transitions current enrollees to a new D-SNP with a different designation and/or eligibility requirements, and renewal options for SNPs with disproportionate share enrollees. We also reference the guidance in our CY 2012 Call Letter; and

- **Zero Part D Cost Sharing for Institutionalized Dual Eligible Beneficiaries: Documentation and Eligibility Requirements (Section 80.4.3).** We list acceptable documents that may be used to demonstrate receipt of home and community-based services (HCBS) and which would make a full benefit dual eligible beneficiary eligible for zero cost-sharing for Part D drugs under §1860D-14 of the *Social Security Act*.

In addition to the above revision in the final version of Chapter 16b, we made other assorted minor clarifications or grammatical changes, including:

- **Hyperlinks to the CY 2012 Call Letter;**

- **Title change for Section 50.8—"Seamless Conversion Option for Newly Medicare Advantage Eligible Individuals";**

- **Addition of Section 60.1 providing "General" disenrollment guidance;**

- **Clarification of Medicaid Cost-sharing for Dual Eligible Individuals (Section 20.2.1).** We add language to explicitly state that Medicaid does not pay towards out-of-pocket costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage. We also add language clarifying that Qualified Medicare Beneficiaries (QMBs), Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QIs) are automatically enrolled in the low-income subsidy (LIS) program and are not subject to the Medicare Part D premium;

- **Clarification of the Role of the NCQA SNP Approval Process in the SNP Application Process (Section 40.2).** We clarify that we have incorporated the NCQA SNP approval process into the general SNP application process, and that SNPs must complete the entire SNP proposal every time they need to be re-approved by the NCQA;

- **Clarification of the Relationship between the NCQA Approval Process and the State Contract Requirement for D-SNPs (Section 40.5.1).** We clarify that the requirement for a State contract and the requirement for NCQA approval are separate requirements, and that D-SNPs must meet both requirements in order to operate;

- **Clarification that D-SNP State Contracts may have Multi-year or Evergreen Contracting Periods (Sections 40.5.1 and 40.5.3).** We clarify that D-SNP State contracts may also be drafted as multi-year or evergreen contracts (i.e., continuously valid until a change is made in the contract) so that the entire calendar year is covered. We also clarify that State contracts for D-SNPs that limit enrollment to dual eligible subsets must either overlap the entire CMS MA contract year, or contain an evergreen clause in the current contract that extends the contract;

- **Clarification of SNP Groupings used to Evaluate Compliance with Meaningful Difference Requirements (Section 80.3).** We add language that explicitly outlines how chronic SNPs (C-SNPs), D-SNPs, and institutional SNPs (I-SNPs) will be evaluated on the meaningful difference criteria; and

- **Clarification of Maximum out-of-Pocket (MOOP) Limits and Cost-sharing Ranges for D-SNPs (Section 80.4.2).** We clarify that, similar to all other local Medicare Advantage (MA) plans, D-SNPs must establish a MOOP limit even though the State Medicaid program is usually paying those costs on the enrollee's behalf. We also clarify that any D-SNP type, other than a zero-cost share D-SNP, must also indicate the cost-sharing range for the plan in the plan's summary of benefits (SB).

We thank the commenters for their insightful feedback and assistance with improving the clarity and comprehensiveness of Chapter 16b. Plans with questions about the policies articulated in Chapter 16b should contact their Regional Office account manager.