Table of Contents

I.   PURPOSE

This document addresses questions regarding Special Needs Plans (SNPs). Questions are categorized into four sections: 1) General SNP Questions; 2) Chronic Condition SNPs; 3) Dual Eligible SNPs; and 4) Institutional SNPs.

II.   GENERAL SNP QUESTIONS

Question: What is a Special Needs Plan?

Answer: A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) designed to provide targeted care and services to individuals with unique needs.[1] "Special needs individuals" have been defined as: 1) institutionalized beneficiaries; 2) Medicare-Medicaid enrollees; and/or, 3) individuals with severe or disabling chronic conditions, as specified by the Centers for Medicare and Medicaid Services (CMS).[2]

Question: What are the payment procedures for SNPs?

Answer: Payment procedures for SNPs mirror the procedures that CMS uses to make payments to non-SNP MA plans. CMS makes advance monthly payments, or capitated payments, to an MA organization for each enrollee for coverage of original Medicare benefits in an MA payment area.[3]

Question: Do SNPs have to offer benefits in addition to those offered in non-SNP MA plans?

Answer: SNP-specific Plan Benefit Packages (PBPs) should incorporate some or all benefits that exceed the basic requirement of Medicare A and B benefits offered by other MA products available in the same service area, such as:

- No or lower beneficiary cost sharing;
- Longer benefit coverage periods for inpatient services;
- Longer benefit coverage periods for specialty medical services;
- Parity between medical and mental health benefits and services;
- Additional preventive health benefits (e.g., dental screening, vision screening, hearing screening, age-appropriate cancer screening, risk-based cardiac screening);
- Social services (e.g., connection to community resources for economic assistance) and transportation services; and,
- Wellness programs to prevent the progression of chronic conditions.[4]

Question: Do SNPs have the same quality improvement requirements as non-SNP MA plans?

Answer: SNPs have the same quality improvement requirements as other MA plans; however, such requirements are tailored to the special needs individuals that the SNP serves. SNPs must conduct

---

[1] SNPs were established by the Medicare Modernization Act of 2003 (MMA)

[2] CMS, Medicare Managed Care Manual (MMCM), chap. 16b, § 10.2 and see 42 Code of Federal Regulations (CFR) § 422.2 which defines special needs individuals and specialized MA plans for special needs individuals

[3] MMCM, chap. 8

[4] Ibid, chap. 16b, § 80.2

both a Chronic Care Improvement Program (CCIP) and a Quality Improvement Project (QIP) targeting the special needs population that it has selected to serve.[5]

Question: What is the SNP enrollment process and how does it differ from the enrollment of non-SNP MA plans?

Answer: SNPs may only enroll individuals who meet the plan's specific eligibility criteria and enrollment requirements.[6] All SNPs are required to verify the applicant's special needs status. SNPs must include elements on the enrollment request mechanism that correspond to the special needs focus of the particular SNP.[7] Although MA organizations must accept enrollment through the Online Enrollment Center (OEC), SNPs may choose whether or not to enroll beneficiaries through the OEC.[8]

Question: What happens if a beneficiary loses his/her special needs status?

Answer: CMS provides a Special Enrollment Period (SEP) for individuals enrolled in an SNP, but are no longer eligible because they no longer meet the specific special needs status.[9] SNPs must send the appropriate notice to the beneficiary explaining their disenrollment.[10]

Question: Are there special marketing requirements for SNPs?

Answer: As with any MA organization, SNPs must market to all individuals eligible to enroll in the plan.[11] Certain marketing provisions are in place, specifically regarding the disclaimer SNPs must place on enrollment eligibility marketing materials targeting potential enrollees and the information SNPs can include related to their National Committee for Quality Assurance (NCQA) SNP approval.[12] Please refer to Section V (Question 9) for special marketing requirements specific to Dual Eligible SNPs.

III. SNP APPLICATION PROCESS

Question: How can an MA apply to offer an SNP?

Answer: Every Medicare Advantage (MA) applicant seeking to offer a Special Needs Plan (SNP) must obtain approval as a Medicare Advantage Prescription Drug (MA-PD) plan. Applicants with a CMS approved MA-PD contract in place only need to complete the SNP portion of the MA application.

The SNP application contains a list of questions and attestations requiring a "yes" or "no" response and requires the applicant to upload documentation in support of responses to the questions and attestations, including the Model of Care (MOC) matrix upload document.[13] SNP applicants can obtain the MA and SNP application for the current contract year at

---

[5] MMCM, chap. 16b, § 90, chap. 5 § 20.2, 20.3 and 42 CFR § 422.152(c)-(d)
[6] Ibid., chap. 16b, § 50.1 and Section 1859(f) of the Social Security Act (the Act)
[7] See chap. 2 for more information on enrollment requirements
[8] MMCM, chap. 16b, § 50.1
[9] Individuals enrolled in a D-SNP always qualify for a SEP. See IV. Dual Eligible SNPs, Question 4
[10] MMCM, chap. 16b, § 50.5 and also see chap. 2, § 30.4 for more information on SEPs
[11] Ibid., chap. 16b, § 70
[12] Ibid., chap. 3, § 50.5
[13] Ibid., chap. 16b, § 40.1

http://www.cms.hhs.gov/MedicareAdvantageApps. All SNP applications must be submitted electronically through the Health Plan Management System (HPMS).

Question: When are SNP applications due?

Answer: The deadline for submitting applications is available in the application package for the current contract year.[14] All SNP applications must be submitted electronically through HPMS by the MA application due date. CMS will not review applications received after the due date and after the due date applicants' access to the HPMS application fields will be blocked.[15]

Question: What criteria should be included in an SNP's MOC?

Answer: CMS is currently revising the existing MOC criteria.

Question: What is the National Committee for Quality Assurance SNP MOC approval process?

Answer: As of January 2012, all SNPs' MOCs must be approved by the NCQA.[16] The NCQA is a non-profit organization that accredits and certifies health care organizations to ensure adherence to health care quality.

The NCQA SNP approval process is based on scoring each of the eleven clinical and non-clinical elements of the MOC in the SNP application.

The scoring methodology consists of three parts:

- **Standard:** In order to operate, an SNP **must achieve a score of 70 percent or greater** on the MOC based on the scoring methodology as described below.
- **Element:** The MOC has 11 clinical and non-clinical elements. Each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:
  - Description of the SNP-specific Target Population;
  - Measurable Goals;
  - Staff Structure and Care Management Goals;
  - Interdisciplinary Care Team;
  - Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
  - MOC Training for Personnel and Provider Network;
  - Health Risk Assessment;
  - Individualized Care Plan;
  - Integrated Communication Network;
  - Care Management for the Most Vulnerable Subpopulations; and,
  - Performance and Health Outcomes Measurement.
- **Factors**: Each element is comprised of multiple factors that NCQA evaluates and scores on a scale of 0 to 4, where 4 is the highest score. Plans are required to provide a response that addresses every applicable factor within each of the eleven elements. Responses should be detailed and include multiple examples and/or case studies. The scores for each factor

---

[14] Both the MA and the SNP application for the current contract year are available at http://www.cms.hhs.gov/MedicareAdvantageApps.
[15] MMCM, chap. 16b, § 40.1
[16] Ibid., § 40.2 and Section 1859(f)(7) of the Act

within a specific element are totaled to provide the overall score for that particular element. There is a total of 160 possible points that can be achieved across the 11 elements based on 40 factors. A passing score is 70 percent.[17]

Question: What if an SNP applicant receives a score below the standard of 70 on their MOC?

Answer: SNPs with an MOC score below the standard of 70 will have one opportunity to resubmit their MOC and achieve a score of 70 or greater. This one-time opportunity is called a cure. To ensure that SNPs submit high quality MOCs, CMS has limited the cure opportunity to just one with only a one-year approval to operate.[18]

Question: Are there different categories of NCQA approval for SNPs?

Answer: SNPs are granted NCQA approval to operate for a certain number of years based on their MOC score. The categories of approval are as follows:

- **Three-year approval:** SNPs that receive a score of 85 or higher on their initial MOC submission will not have to submit a new MOC until the end of the third year of operating.
- **Two-year approval:** SNPs that receive a score between 75 and 84 on their initial MOC submission will not have to submit a new MOC until the end of the second year of operating.
- **One-year approval:** SNPs that receive a score between 70 and 74 on their initial MOC submission, **OR** SNPs that score less than 70 on their initial MOC submission and subsequently achieve a score of 70 or higher after they have had one opportunity to cure, will submit a new MOC at the end of the first year of operating.

This approval process provides incentive for SNPs to develop and submit comprehensive MOCs by rewarding a longer term of approval to SNPs with high-quality MOCs.[19]

Question: When does an MA organization have to submit a new SNP application and MOC?

Answer: An MA organization must submit a new SNP application[20] and MOC under the following circumstances:

- The MA organization seeks to offer a new SNP
- The MA organization seeks to expand its existing service area[21]
- The MA organization operating a D-SNP expects to change its approved dual eligible subset[22]

When approval periods for MA organizations with existing SNPs expire, SNPs must submit new MOCs but are **not** required to submit SNP applications.[23]

---

[17] The scoring methodology is currently being revised and will reside in MMCM, chap. 5 once complete.
[18] MMCM, chap. 16b, § 40.2
[19] Ibid.
[20] The SNP portion of the MA application
[21] In this circumstance, the MA organization must submit both the SNP portion and SAE portions of the MA application
[22] See Section IV., Question 1 of this document for the five types of D-SNPs
[23] MMCM, chap. 16b, § 40.3

IV. CHRONIC CONDITION SNPS

Question: What is a Chronic Condition Special Needs Plan?

Answer: Chronic Condition Special Needs Plans (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.[24] Approximately two-thirds of Medicare beneficiaries have multiple chronic conditions requiring coordination of care among primary providers, medical and mental health specialists, inpatient and outpatient facilities, and extensive ancillary services related to diagnostic testing and therapeutic management. C-SNPs are designed to narrowly target enrollment to Medicare beneficiaries who have severe or disabling chronic conditions.[25]

Question: What are the specific chronic conditions required to be eligible for a C-SNP?

Answer: Special needs individuals with severe or disabling chronic conditions are defined as individuals "who have one or more co-morbid and medically complex chronic conditions that are substantially disabling or life threatening; have a high risk of hospitalization or other significant adverse health outcomes; and require specialized delivery systems across domains of care."[26] CMS has approved 15 SNP-specific chronic conditions (see Figure 1 below).

Figure 1: The SNP Chronic Condition Panel developed a list of 15 SNP-specific chronic conditions

1. Chronic alcohol and other drug dependence
2. Autoimmune disorders limited to:
    - Polyarteritis nodosa
    - Polymyalgia rheumatica
    - Polymyositis
    - Rheumatoid arthritis
    - Systemic lupus erythematosus
3. Cancer, excluding pre-cancer conditions or in-situ status
4. Cardiovascular disorders limited to:
    - Cardiac arrhythmias
    - Coronary artery disease
    - Peripheral vascular disease
    - Chronic venous thromboembolic disorder
5. Chronic heart failure
6. Dementia
7. Diabetes mellitus
8. End-stage liver disease
9. End-stage renal disease requiring dialysis
10. Severe hematologic disorders limited to:
    - Aplastic anemia
    - Hemophilia
    - Immune thrombocytopenic purpura
    - Myelodysplatic syndrome
    - Sickle-cell disease (excluding sickle-cell trait)
    - Chronic venous thromboembolic disorder
11. HIV/AIDS
12. Chronic lung disorders limited to
    - Asthma
    - Chronic bronchitis
    - Emphysema
    - Pulmonary fibrosis
    - Pulmonary hypertension
13. Chronic and disabling mental health conditions limited to:
    - Bipolar disorders
    - Major depressive disorders
    - Paranoid disorder
    - Schizophrenia
    - Schizoaffective disorder
14. Neurologic disorders limited to:
    - Amyotrophic lateral sclerosis (ALS)
    - Epilepsy
    - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
    - Huntington's disease
    - Multiple sclerosis
    - Parkinson's disease
    - Polyneuropathy
    - Spinal stenosis
    - Stroke-related neurologic deficit
15. Stroke

---

[24] 42 CFR § 422.2
[25] MMCM, chap. 16b, § 20.1.1
[26] MMCM, chap. 16b, § 20.1.2, Section 1859(b)(6)(B)(iii) of the Act and 42 CFR § 422.2

CMS periodically re-evaluates the 15 approved chronic conditions as it gathers evidence on the effectiveness of care coordination through the SNP product, and as health care research demonstrates advancements in chronic condition management.[27]

Question: What should a C-SNP PBP include?

Answer: C-SNPs are expected to have specially-designed PBPs that go beyond the provision of basic Medicare Parts A and B services and care coordination required of all CCPs.

These specially-designed PBPs should include, but not be limited to:

- Supplemental health benefits specific to the designated chronic condition;
- Specialized provider networks specific to the designated chronic conditions; and,
- Appropriate enrollee cost sharing structured around the designated chronic conditions and co-morbidities for all Medicare-covered and supplemental benefits.[28]

Question: Are there different types of C-SNPs?

Answer: When completing the SNP application, Medicare Advantage (MA) organizations can choose to offer a C-SNP that targets any one of the groups below:

- A single CMS-approved chronic condition;
- A CMS-approved group of multiple chronic conditions; or,
- An MA organization-customized grouping of multiple chronic conditions selected from the 15 CMS-approved, SNP-specific chronic conditions.[29]

Question: Can multiple chronic conditions be grouped under one C-SNP?

Answer: C-SNPs are permitted to target a group of multiple chronic conditions in cases where the conditions are commonly co-morbid and clinically linked. CMS will accept applications with the following multi-condition groupings:

- Group 1: Diabetes mellitus and chronic heart failure;
- Group 2: Chronic heart failure and cardiovascular disorders;
- Group 3: Diabetes mellitus and cardiovascular disorders;
- Group 4: Diabetes mellitus, chronic heart failure, and cardiovascular disorders; and,
- Group 5: Stroke and cardiovascular disorders.[30]

For MA organizations that are approved to offer a C-SNP targeting one of the above-listed groups, beneficiaries need only to have **one** of the qualifying conditions for enrollment. CMS will review the Model of Care (MOC), provider network, and benefits package specified in the application for

---

[27] MMCM, chap. 16b, § 20.1.2
[28] Ibid., § 40.7.1
[29] Ibid., § 40.7.2
[30] Ibid., § 40.7.3

the multi-condition SNP to determine adequacy in terms of creating a specialized product for the chronic conditions it serves.[31]

Question: Can MA organizations develop their own multiple condition SNP combinations for beneficiaries?

Answer: MA organizations may develop their own multiple condition SNP combinations for enrollees. MA organizations that pursue this customized option must verify that enrollees have **all** of the qualifying conditions in the combination and are limited to groupings of the same 15 CMS-approved chronic conditions that other C-SNPs must select. CMS carefully assesses prospective multiple condition SNP proposals to determine the adequacy of its care management system for each condition in the combination.[32]

Question: How is eligibility for a C-SNP verified?

Answer: To determine eligibility for a special needs individual to enroll in a C-SNP, CMS requires that the C-SNP contact the applicant's existing provider to verify the enrollee has the qualifying conditions. C-SNPs must reconfirm a beneficiary's eligibility at least annually.

MA organizations may request CMS approval to use a Pre-enrollment Qualification Assessment Tool in its process for verifying that a beneficiary is eligible to enroll in a particular C-SNP. C-SNPs that enroll applicants based on the information collected using a CMS-approved Pre-enrollment Qualification Assessment Tool must obtain confirmation of the qualifying chronic condition(s) from the existing provider during the first month of enrollment. The organization must inform each enrollee that he/she will be disenrolled from the plan by the end of the second month if eligibility cannot be verified during the first month of enrollment.[33]

V. DUAL ELIGIBLE SNPS

Question: What is a Dual Eligible Special Needs Plan?

Answer: Dual Eligible Special Needs Plans (D-SNPs) are SNPs that enroll beneficiaries who are entitled to both Title XVIII (Medicare) and Medical Assistance from a State/Territorial plan under Title XIX (Medicaid) of the Social Security Act (the Act). There are five categories of D-SNPs, according to the types of beneficiaries[34] that can enroll:

- **All-Dual D-SNPs**
  Enrollment is limited to beneficiaries who are eligible for Medicare Advantage (MA) and who are entitled to medical assistance under a State/Territorial plan under Title XIX of the Act. An all-dual D-SNP must enroll all categories of dual eligible individuals, including those with comprehensive Medicaid benefits as well as those with more limited cost sharing.
- **Full-Benefit D-SNPs**

---

[31] MMCM, chap. 16b, § 40.7.3
[32] Ibid., § 40.7.4
[33] Ibid., § 50.2.2.3
[34] Ibid., § 20.2.1 or question 3 below for the seven categories of Medicaid eligibility for which a beneficiary can qualify

Enrollment is limited to individuals who are eligible for the following medical assistance:

(1) Full Medicaid benefits for the month under any eligibility category covered under the Medicaid State plan; or,

(2) Medical assistance for any month if the individual was eligible for medical assistance in any part of the month.

- **Medicare Zero Cost Sharing**
  Enrollment is limited to the two categories of dual eligible beneficiaries who are not financially responsible for cost sharing for Medicare Parts A or B – Qualified Medicare Beneficiaries (QMB)-only and QMBs with comprehensive Medicaid benefits (QMB+).[35] QMB-only individuals are not entitled to full Medicaid benefits and Medicaid cost sharing may be required.

- **Dual Eligible Subset**
  An MA organization that offers D-SNPs may exclude specific groups of dual eligible individuals based on the organization's coordination efforts with State Medicaid Agencies (SMAs). CMS reviews and approves requests for coverage of dual eligible subsets on a case-by-case basis.

- **Dual Eligible Subset – Medicare Zero Cost Sharing**
  A dual eligible subset, as described above, but one that does not include cost sharing.[36]

Question: How is an individual determined to be a dual eligible?

Answer: "Dual eligible" is a term used to encompass all Medicare beneficiaries who also receive Medicaid assistance, ranging from beneficiaries who receive the full range of Medicaid benefits to beneficiaries who receive assistance only with Medicare premiums or cost sharing. Dual eligible coverage is dependent on beneficiaries' income and asset thresholds.[37]

Question: What are the Medicaid eligibility categories?

Answer: Dual eligible beneficiaries fit into one of the seven categories of Medicaid eligibility. States may vary in determining their eligibility categories so there may be State-specific differences in the eligibility categories. The general Medicaid eligibility categories include the following:

- **QMB only**
  An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is **not** otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State plan.

- **QMB+**

---

[35] QMBs-only are individuals entitled to Medicare Part A, with an income of 100% Federal Poverty Level (FPL) or less, and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is **not** otherwise eligible for full Medicaid benefits through the State. QMB+ are individuals who meet the standards for QMB eligibility and who also meet the criteria for full Medicaid benefits.

[36] MMCM, chap. 16b, § 20.2.1 - 20.2.5

[37] Ibid., § 20.2.1

An individual who meets the standards for QMB eligibility, and who also meets the criteria for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level.

- **Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB-only)**
An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed twice the SSI limit, and who is **not** otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits.

- **SLMB+**
An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full Medicaid benefits. These individuals are entitled to payment of the Medicare Part B premium, in addition to full Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level.

- **Qualifying Individual (QI)**
An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is **not** otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium.

- **Qualified Disabled and Working Individual (QDWI)**
An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only.

- **Other full benefit dual eligible (FBDE)**
An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers.[38]

Question: What is the D-SNP enrollment process?

Answer: D-SNP beneficiaries qualify for SEP and are able to enroll and/or switch plans not only during the annual enrollment period, but also at the start of every month.[39] An individual can enroll in a D-SNP via the internet at www.medicare.gov, by phone at 1-800-MEDICARE, or by contacting his/her State D-SNP directly.[40]

---

[38] MMCM, chap. 16b, § 20.2.1
[39] Ibid., chap. 2, § 30.4
[40] Ibid., chap. 2, § 40.1

Question: What is a Fully Integrated Dual Eligible (FIDE) SNP and what criteria must a D-SNP meet to be considered a FIDE SNP?

Answer: Fully Integrated Dual Eligible (FIDE) SNPs are D-SNPs that meet the following five elements:

- Enrolls special needs individuals entitled to medical assistance under a Medicaid State plan;
- Provides dual eligible beneficiaries access to Medicare and Medicaid benefits under a single Managed Care Organization (MCO);
- Has a CMS-approved Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contract with an SMA that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk based financing;
- Coordinates the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and
- Employs policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.[41]

Further, the Act[42] provides the authority to apply a frailty payment under Program of All-Inclusive Care for the Elderly (PACE) payment rules if an SNP meets the five elements to be considered a FIDE SNP and has similar average levels of frailty as PACE organizations.[43] CMS announces its methodology for determining whether a FIDE SNP has a similar average level of frailty to PACE annually.[44] CMS also notifies FIDE SNPs annually of their frailty score and how they compare to PACE.

Question: Some States do not capitate all long-term care benefits. Can a plan in these States continue to meet the requirements to be considered a FIDE SNP?

Answer: To be eligible for FIDE SNP status, primary, acute, and long-term care benefits must be capitated for each contract year. However, CMS will permit long-term care carve-outs and exclusions if the D-SNP demonstrates that it meets the following criteria:

- The plan must be at risk for substantially all of the services under the capitated rate;
- The plan must be at risk for nursing facility services for at least six months of the year;
- Individuals must not be disenrolled from the plan as a result of exhausting the services covered under the capitated rate; and

---

[41] As defined in section 1859(b)(6)(B)(ii) of the Social Security Act (the Act) and 42 CFR § 422.2, and the MMCM Chap. 16b, § 40.4.3

[42] Section 1853(a)(1)(B) of the Act

[43] In addition to Section 1853(a)(1)(B) of the Act, please also refer to MMCM Chap. 16b, § 30.2

[44] MMCM Chap. 16b, § 30.2. Also, see "Announcement of Calendar Year Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies" and the Final Call Letter. Adhere to the most recent version of the Final Call Letter as the Call Letter is released annually.

- The plan must remain responsible for managing all benefits, including any carved-out service benefits, notwithstanding the method of payment (e.g., fee-for-service, separate capitated rate) received by the plan.[45]

Since the criteria can change annually, please refer to the most recent version of the Call Letter outlining the criteria that a plan must meet to receive a FIDE SNP designation without the provision of long-term care services.

Question: What is the benefit flexibility option for D-SNPs?

Answer: D-SNPs that meet a high standard of integration and quality-based standards are allowed to offer supplemental benefits beyond those allowed for MA plans.[46] The supplemental benefits are not designed to replace Medicaid benefits but rather to help bridge the gap between Medicare and Medicaid covered services.

Question: How does a D-SNP qualify for the benefit flexibility option?

Answer: In order to meet the requirements to qualify for the benefits flexibility option, the D-SNP must:

- Be a specialized MA plan for dual eligible special needs individuals;[47]
- Be operational in the upcoming contract year and have operated the entire previous contract year;
- Facilitate access to all covered Medicare benefits and all Medicaid benefits covered in the State Medicaid plan;
- Have a capitated contract with an SMA that includes coverage of specified primary, acute, and long-term care benefits and services to the extent capitated coverage is consistent with State policy;
- Coordinate delivery of covered Medicare and Medicaid primary, acute, and long-term care services throughout its entire service area; and
- Possess a valid contract arrangement with the State, as approved by CMS.[48]

Additionally, the D-SNP must do the following:

- Have received a three-year approval of its Model of Care (MOC) by the National Committee for Quality Assurance (NCQA);[49] and
- Either
  (1) Be in a contract with a three-Star[50] (or higher) overall rating for the previous contract year on the Medicare Plan Finder website; or

---

[45] For further guidance, please refer to MMCM Chap. 16b, § 40.4.3

[46] 42 C.F.R. § 422.102(e)

[47] As described in Section 1859(b)(6)(B)(ii) of the Act

[48] 42 C.F.R. § 422.107

[49] To receive a three-year National Committee for Quality Assurance (NCQA) approval, plans must receive a score of 85 percent or higher on NCQA's evaluation of the plans' Model of Care (MOC). The scoring criteria established by the CMS are based on 11 clinical and nonclinical MOC elements.

[50] Star Ratings summarize the quality and performance of Part C and Part D contracts and cover as many as 50 measures for an MA contract.

(2) When the D-SNP is in a contract that does not have sufficient enrollment to generate a Star rating, have high ratings on selected SNP plan-level Health Plan Employer Data and Information Set (HEDIS) measures.[51]

For further guidance, please refer to the most recent annual Call Letter.

Question: Are there special marketing requirements for D-SNPs?

Answer: In addition to the special marketing requirements for SNPs described above in Section II (Question 7), D-SNPs must provide each prospective enrollee prior to enrollment with a comprehensive written statement that describes the benefits and cost-sharing protections the individual is entitled to under Medicaid and that are covered by the D-SNP.[52]

VI. INSTITUTIONAL SNPS

Question: What is an Institutional Special Needs Plan?

Answer: Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to Medicare Advantage (MA) eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility (ICF) for the developmentally disabled, or an inpatient psychiatric facility.[53]

Question: Can an I-SNP enroll an individual prior to having 90 days of institutional level of care?

Answer: An I-SNP can enroll an individual prior to having at least 90 days of institutional level care if the I-SNP completes a CMS-approved needs assessment showing that the individual's condition makes it likely that either the length of stay or the need for an institutional level-of-care will be at least 90 days.[54]

Question: Can individuals enroll in an I-SNP if they do not reside in an institution?

Answer: I-SNPs will enroll MA eligible individuals living in the community, and not in an institution, if they meet both of the following eligibility requirements:

- The I-SNP must determine that an institutional level-of-care is needed based on the use of a State assessment tool. The assessment tool used for persons living in the community must be the same as that used for individuals residing in an institution. In States and Territories without a specific tool, SNPs must use the same level-of-care determination methodology used in the respective State or Territory in which the SNP is authorized to operate.

---

[51] A plan must receive 75 percent or greater on at least five of the following measures: Controlling Blood Pressure, Appropriate Monitoring of Patients Taking Long-Term Medications, Board Certified Physicians (Geriatricians), Care for Older Adults—Medication Review, Care for Older Adults—Functional Status Assessment, Care for Older Adults—Pain Screening, and Medicaid Reconciliation Post-Discharge.

[52] MMCM, chap. 3, § 60.1

[53] Ibid., chap. 16b, § 20.3.1

[54] Ibid., § 50.2.2

- The I-SNP must arrange to have the level-of-care assessment administered by an independent, impartial party with the requisite professional knowledge to accurately identify institutional level-of-care needs.[55]

Question: What are the service area requirements for an I-SNP?

Answer: CMS may allow an I-SNP that operates either single or multiple facilities to establish a county-based service area as long as it has at least one long-term care facility that can accept enrollment and is accessible to the county residents.[56]

Question: What happens if an individual changes residence?

Answer: If an I-SNP enrollee changes residence, the SNP must document that it is prepared to implement a CMS-approved Model of Care (MOC) at the enrollee's new residence in another institution, or in another setting that provides an institutional level of care, as long as the enrollee still resides within the I-SNP's service area. If the MA organization operating the I-SNP did not submit MOCs for the type of residence in which the enrollee is relocating, such as an LTC facility, the MA organization is required to give the beneficiary the option to disenroll.[57]

Question: What are the LTC facility contract requirements for I-SNPs?

Answer: I-SNPs that serve residents of LTC facilities must own, operate, or have a contractual arrangement with the LTC facility that includes adherence to its approved MOC. The eight contract requirements include:

- Facilities in a chain organization must be contracted to adhere to the MOC;
- Facilities must provide access to clinical staff;
- Facilities must provide protocols for the MOC;
- Delineation of services provided by the I-SNP staff and the LTC facility staff must be specified;
- Training plan for LTC facility staff to understand the MOC must be included;
- Procedures must be developed and in place for facilities to maintain a list of credentialed I-SNP clinical staff;
- Contract year for I-SNP must be specified; and
- Grounds for early termination and transition plan for beneficiaries enrolled in the I-SNP must be specified.[58]

---

[55] MMCM, chap. 16b, § 50.2.2
[56] Ibid., § 40.4.1
[57] Ibid., § 20.3.3
[58] Ibid., § 40.6