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DRAFT

I. PURPOSE

The purpose of this document is to address questions that are frequently asked by the States to assist them in the Dual-Eligible Special Needs Plan (D-SNP) contracting process. This Frequently Asked Questions (FAQ) document compiled questions that were submitted to the State Resource Center (SRC) mailbox and that were asked at Knowledge Sharing Forums or other SRC-related events and will be shared as a resource to the States on the SRC website.¹ Questions are categorized into six sections: 1) General Questions; 2) Compliance; 3) State Medicaid Agency Contract Design; 4) State Medicaid Agency Contract Submission; 5) Fully Integrated Dual Eligible Special Needs Plans; and 6) Financial Alignment Demonstration.

II. GENERAL QUESTIONS

Question: What is a Dual Eligible Special Needs Plan (D-SNP)?

Answer: A D-SNP is a Special Needs Plan (SNP) that enrolls beneficiaries who are entitled to both Title XVIII (Medicare) and Medical Assistance from a State Plan under Title XIX (Medicaid) of the Social Security Act (the Act). There are five categories of D-SNPs, according to the types of beneficiaries² 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:** 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+)³. 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 eligibles based on the organization's coordination efforts with State Medicaid agencies (SMAs). The Centers for Medicare and Medicaid Services (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.⁴

¹ <http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/StateResourceCenter.html>

² See Medicare Managed Care Manual (MMCM), chap. 16b, § 20.2.1 for the seven categories of Medicaid eligibility for which a beneficiary can qualify

³ 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.

⁴ MMCM, chap 16b, § 20.2.1 - 20.2.5

Question: How can an MA organization offer a D-SNP?

Answer: Every MA applicant seeking to offer a D-SNP must obtain approval as an MA-PD plan.⁵ MA-PD applications are due by the end February. 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.⁶ SNP applicants can obtain the MA and SNP application for the current contract year at <http://www.cms.hhs.gov/MedicareAdvantageApps>. All SNP applications must be submitted electronically through HPMS by the MA or MA-PD application due date.

In addition, the MA organization must enter into a contract with the SMAs in the states in which the D-SNP intends to operate. The SMA contract must be submitted into HPMS by July 1 for consideration for the next contract year. The contract between the MA organization and the SMA must document how the D-SNP will meet the eight MIPPA elements:

1. MA organization’s responsibilities, including financial obligations, to provide or arrange for Medicaid benefits;
2. Category or categories of eligibility for dual eligible beneficiaries to be enrolled under the SNP, including the targeting of specific subsets;
3. Medicaid benefits covered under the SNP;
4. Cost-sharing protections covered under the SNP;
5. Identification and sharing of information on Medicaid provider participation;
6. Verification process of an enrollee’s eligibility for both Medicare and Medicaid;
7. Service area covered under the SNP; and
8. Contracting period.⁷

Question: What is a *capitated contract* and how does it apply to the implementation of a D-SNP?

Answer: A capitated contract is a contractual agreement through which a D-SNP agrees to provide specified health care services to beneficiaries for a fixed dollar amount per member, per month.⁸ The D-SNP contractor and the State may enter into a capitated arrangement for Medicaid benefits, but a capitated arrangement is not required.

Question: Do D-SNPs provide the same benefit package as Original Medicare? How can a State benefit from contracting with a D-SNP?

Answer: At a minimum, a D-SNP’s benefit package must include all benefits the enrollees would be entitled to under Original fee-for-service (FFS) Medicare (Parts A and B) and prescription drug benefits enrollees would be entitled to under Medicare Part D. MA organizations typically provide supplemental benefits not available under Original Medicare. These benefits must be submitted to, and approved by, CMS as part of the annual MA bid process before being offered to enrollees.⁹ States can negotiate with MA organizations to determine what supplemental benefits the D-SNP will cover. For example, States can negotiate with a D-SNP contractor to cover some Medicaid

⁵ Prescription Drug Benefit Manual, chap. 5, § 20.1

⁶ MMCM, chap. 16b, § 40.1

⁷ Ibid., § 40.5.1

⁸ For more information on capitated arrangements, please refer to the MMCM, chap. 1, § 10, chap. 8 and chap. 16b, § 30

⁹ MMCM, chap. 1, § 10

services (e.g., vision and dental services) as supplemental benefits, thus realizing savings under the State's Medicaid program. States can also work with a D-SNP contractor to provide additional services for their dual eligible population.

Question: Must all MA organizations that enroll dual eligible beneficiaries be designated as a D-SNP?

Answer: No, MA organizations may enroll a dual eligible in plans other than D-SNPs; however, only D-SNPs can provide or arrange for a dual eligible's Medicaid benefits. D-SNPs tailor their benefits to meet the needs of the dual eligible population and can enroll only beneficiaries eligible for Medicare and Medicaid.¹⁰ Each dual eligible beneficiary can determine whether a regular MA plan or a D-SNP is most appropriate to meet the individual's needs.

III. COMPLIANCE

Question: Which D-SNPs are required to have a contract with the State?

Answer: Federal law, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires all MA organizations operating a D-SNP to obtain a contract with the SMA in each state in which the D-SNP operates. The MA organization retains responsibility under the contract for providing benefits, or for arranging for benefits to be provided, to individuals entitled to receive medical assistance under Title XIX (Medicaid).¹¹

Question: Is it the State's responsibility to initiate a D-SNP contract?

Answer: It is not the State's responsibility to initiate a D-SNP contract. The MA organization should approach the State if the organization wants to operate a D-SNP or contract with a D-SNP operating in the State. All D-SNPs are required to have contracts with the States in which they operate.

Question: Do State Medicaid Agencies have to contract with MA organizations?

Answer: States are not required to contract with MA organizations. States may be selective in choosing to contract with an MA organization, particularly if doing so does not support the State's overall benefit integration strategy.

Question: Does CMS allow for a D-SNP to subcontract with a Managed Care Organization (MCO) in place of directly contracting with a SMA?

Answer: CMS expects D-SNPs to contract directly with SMAs; however, they recognize that some States are only able to contract directly with a limited number of D-SNPs due to State statutory requirements, budgetary concerns, and limited resources. When these circumstances are present, CMS will consider subcontracting arrangements with a State Medicaid MCO to be equivalent to a direct State contract as long as the subcontract contains all MIPPA required elements and the arrangement has been approved by the State.¹²

¹⁰ "Types of MA Plans," 42 C.F.R. § 422.4(a)(1)(iv)

¹¹ "Special Needs Plans and Dual Eligibles: Contract with State Medicaid Agency," 42 C.F.R. § 422.107(b)

¹² Health Plan Management Systems (HPMS) Memo, "Guidance for Submitting State Medicaid Agency Contracts", May 1, 2013

Question: If an MA plan and a SMA have agreed to a multiyear contract, what are the annual CMS contract update requirements?

Answer: Multiyear and/or “evergreen” contracts have automatic renewal statements and are valid until a contract change is made. A fully executed and signed contract amendment would be required to expand a service area.¹³ All contracts (including multiyear and evergreen contracts) must be uploaded each year to the Health Plan Management System (HPMS) even if the contract has not changed since the previous year’s submission. Annually, CMS also requires a letter from the State verifying that the State intends to continue the evergreen contract with the D-SNP.¹⁴

Question: What steps must D-SNPs take to non-renew their plan with CMS?

Answer: SNPs are offered at the plan benefit package (PBP) level, not at the contract level. If the D-SNP chooses to non-renew under a particular contract, the D-SNP must do so by the first Monday in June via the plan creation module in HPMS. To non-renew the D-SNP, the plan must be deleted in HPMS during plan creation. For non-renewal steps at the contract level, please refer to 42 C.F.R. 422.506.

Question: If a D-SNP will no longer be operating, what happens to the members in that plan?

Answer: When a D-SNP stops operating, members will be sent 60 days’ notice of the nonrenewal or termination. Additionally, members will have the option to i) join other D-SNPs operating in their service area, or ii) join other MA plans in their service area. D-SNPs, as a rule, cannot move members automatically to one of their MA plans without the members making an affirmative selection. Individuals who do not elect an MA plan before the termination effective date will be defaulted to Original (FFS) Medicare and a Medicare Advantage Prescription Drug (MA-PD) Plan on the effective date of the termination.¹⁵ If the plan requests and receives CMS approval for a crosswalk, it may use the HPMS plan creation module to crosswalk its members. Notification requirements must still be met.

Question: Who is responsible for providing the care management services mandated by MIPPA?

Answer: Any MA organization offering a SNP is required to meet the care management requirements in Section 164(d) of MIPPA, including conducting an initial assessment and annual reassessment (also known as a *health risk assessment*¹⁶) of the enrollee, developing an individualized care plan¹⁷ for each enrollee, using an interdisciplinary care management team, and having an evidence-based model of care (MOC) with appropriate networks of providers and specialists.

Question: What is the State’s responsibility in the role of care coordination? Can this activity be managed exclusively by the MA organization?

Answer: States may contract with MA organizations to provide coordination of Medicaid services. Per MIPPA, the process by which the SMA provides and arranges for Medicaid benefits and services must be clearly outlined in the contract by and between the SMA and the entity. To be compliant with MIPPA and CMS regulations, the contract must, at a minimum, describe the MA organization’s responsibility to integrate and coordinate Medicare and Medicaid benefits.

¹³ MMCM, chap. 16b, § 40.5.1

¹⁴ CMS does not require a letter from the State for multiyear contracts since a written contract is in place for a specific period of time.

¹⁵ MMCM, chap. 2 § 30.4.3

¹⁶ 42 C.F.R. § 422.101 (f)(i)

¹⁷ 42 C.F.R. § 422.101 (f)(ii)

CMS requires States and MA organizations to share sufficient data with each other in order for States to properly monitor the MA organization's adherence to the SMA contract. CMS expects that these communications will include, at minimum, information on the providers that contract with the SMA, as well as information needed to verify enrollees' Medicaid eligibility.

Question: Are States responsible for approving the D-SNP Summary of Benefits?

Answer: Although States can assist D-SNPs in developing the plan Summary of Benefits, CMS is responsible for approving each Summary of Benefits document.

MIPPA mandates that each D-SNP provide prospective enrollees, prior to enrollment, with a comprehensive written statement using a standardized content and format.¹⁸

Question: May a State that has existing Medicaid managed care contracts establish D-SNP contracts through an amendment to those contracts?

Answer: States may not establish a D-SNP contract through an amendment to an existing Medicaid managed care contract. An MA organization must go through the CMS MA and SNP application process to operate as a D-SNP. Although portions of the existing Medicaid managed care contracts may be similar to the contract language established between the State and the D-SNP, D-SNPs must establish stand-alone contracts with States.

Question: If a D-SNP is both an MA plan and an MCO, does its contract go through two separate contract reviews at CMS?

Answer: Yes, all D-SNPs that have both an MA plan and an MCO undergo two independent review processes to ensure adherence to the MIPPA requirements and to Medicaid managed care requirements. Further, CMS reviews and approves a D-SNP while the State reviews and approves an MCO.

Question: Can an MA D-SNP change its service area after having submitted an application?

Answer: The same rules that apply to the MA plan with respect to service area changes also apply to D-SNPs. These rules are set forth in the Medicare Managed Care Manual (MMCM), Chapter 16b, Section 40.4. The MMCM states that a D-SNP may not expand its service area after submission of an application. A request for a service area expansion would need to be submitted during the next CMS application cycle; however, a request to reduce the service area may be acceptable under certain conditions.

Question: How is the length of a SNP contract period determined? Does the duration of the contract need to be stated within the contract?

Answer: According to MIPPA element 8, the SNP contract should cover the CMS contract year period, which is from January 1 to December 31. Contracts may be developed as multiyear or evergreen contracts (i.e., with an automatic renewal feature) so that the next contract year (or other period, if applicable) is covered.

Question: How is the length of a D-SNP member's enrollment determined?

Answer: Once a member is enrolled in a D-SNP, the member maintains enrollment unless they are voluntarily or involuntarily disenrolled.

¹⁸ MIPPA § 164(c)(3)(C)

Question: Can the D-SNP member's enrollment be terminated involuntarily, or must the enrollment be continued until the individual chooses to disenroll voluntarily?

Answer: D-SNP members may voluntarily disenroll from a plan or change plans at any time effective the first day of the month following the month when the voluntary disenrollment was requested.

Under certain circumstances, D-SNP members may be disenrolled involuntarily. See the MMCM, Chapter 2, Section 50.2, for details and instances requiring involuntary disenrollment. In addition to those instances described in the MMCM, because D-SNPs may only enroll individuals who continue to meet the plan's specific eligibility criteria, if the beneficiary no longer meets special needs status, they would be involuntarily disenrolled. In this situation, the D-SNP must continue member care for at least one month. A D-SNP may provide coverage for up to six months, provided that the plan can continue to furnish appropriate care. In addition, a dual eligible individual who loses Medicaid eligibility can be deemed eligible for the plan if that individual would likely regain eligibility within six months. Members who do not requalify within this time period must be involuntarily disenrolled, with proper notice, from the plan at the end of this period. The D-SNP may choose any length of time from 30 days through six months for deeming continued eligibility as long as the D-SNP applies the criteria consistently among all members and fully informs members of its policy.¹⁹

Under any circumstance, the D-SNP must provide the beneficiary with a minimum of 30 days notice after the plan determines that the member is no longer eligible. Notice must provide members with an opportunity to prove that they are still eligible to be in the plan and will inform the individuals that they can enroll in another MA plan or obtain coverage to supplement Original Medicare.

Question: What are the marketing guidelines or requirements for D-SNPs?

Answer: D-SNPs must follow the same marketing guidelines as all MA plans.²⁰ Similar to all MA plans, SNPs must market to all individuals eligible to enroll in the plan.²¹ Since D-SNPs must limit enrollment to dual eligible individuals, D-SNPs can work with the States to identify an acceptable method of targeting dual eligible beneficiaries.²² CMS will also work with States to coordinate language for explanatory marketing materials such as the plan Summary of Benefits.

Question: Who determines annual maximum out-of-pocket limits: SMAs or MA SNPs?

Answer: MA SNPs, not SMAs, determine their maximum out-of-pocket (MOOP) limits, with CMS approval. However, it is important to note that D-SNPs may not impose cost-sharing requirements that exceed the amounts permitted under the State Medicaid Plan if the individual was not enrolled in the D-SNP.²³ Plans should refer to the most recent version of the Call Letter for MA organizations for additional guidance on establishing their MOOP limits.

Question: Are D-SNPs required to provide Medicaid benefits for their enrollees?

Answer: At a minimum, MIPPA requires plans to arrange for the provision of Medicaid benefits for enrollees. This requirement ensures that dual-eligible beneficiaries receive their Medicare and

¹⁹ MMCM, chap. 16b, § 50.4.

²⁰ See MMCM, chap. 3 and the Prescription Drug Benefit Manual, chap. 2 for more information on marketing guidelines

²¹ MMCM, chap. 16b, § 70

²² Ibid.

²³ Ibid., § 80.4.2

Medicaid benefits in a coordinated manner. A D-SNP's specific responsibilities (financial or otherwise) to arrange for Medicaid benefits may vary according to its arrangement with the State. Further information on D-SNP-specific responsibilities can be found in the MMCM, Chapter 16b, Section 40.5.1.

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

Answer: Regulations at 42 C.F.R. § 422.102(e) allow D-SNPs that meet a high standard of integration and quality-based standards to offer supplemental benefits beyond those allowed for MA plans. 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 dually-eligible special needs individuals;²⁴
- 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 in accordance with the requirements at 42 C.F.R. § 422.107.

Additionally, the D-SNP must do the following:

- Have received a three-year approval of its MOC by the National Committee for Quality Assurance (NCQA);²⁵ and
- Either
 - Be in a contract with a three-Star²⁶ (or higher) overall (i.e., Parts C and D) rating for the previous contract year on the Medicare Plan Finder website; or
 - 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.²⁷

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

²⁴ As described in Section 1859(b)(6)(B)(ii) of the Act

²⁵ To receive a three-year approval from the NCQA, plans must receive a score of 85 percent or higher on NCQA's evaluation of the plans' MOC. The scoring criteria established by the CMS are based on 11 clinical and nonclinical MOC elements.

²⁶ 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.

²⁷ 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.

Question: Do SNPs have an internal audit requirement in their contracts with CMS? What are the parameters regarding the internal audit?

Answer: Yes, the internal audit is part of the compliance program that must be implemented in order to qualify as an MA organization –and SNPs must be qualified MA organizations. The compliance program must, at a minimum, include the following audit requirements:

- Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.
- Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.²⁸

Question: If a SMA has a coordination of benefits only contract with a SNP, do the Medicaid services have to be listed in the contract?

Answer: Yes, the SMA contract must document each entity's role and responsibility with regard to dual-eligible individuals and must cover specific regulatory requirements, including the Medicaid benefits covered by the SNP, as required under MIPPA element three.

Meeting MIPPA element three requires that the information provided in the contract include the benefit design, how it will be administered, and state that it is the plan's responsibility to provide or arrange for this benefit. The contract should specify the benefits offered in the State plan as well as benefits that go beyond Original Medicare parameters that the SNP will offer. If the list of services is an attachment to the contract, the SNP must reference the list in the body of the contract.²⁹

Question: What are the actions CMS takes once determining that a D-SNP contract is missing MIPPA-required language?

Answer: CMS Central Office (CO) and Regional Offices (ROs) work together when reviewing and approving contracts. However, communication with States and MA organizations regarding contracts primarily comes from CMS ROs. Each RO works closely with States and MA organizations to identify contract deficiencies and assist all parties in revising contracts to meet MIPPA and other requirements. If any MIPPA elements are not met, the D-SNP will receive a deficiency letter. CMS will permit a 30-day cure period for the D-SNP to correct the noted deficiencies.

Question: How should a plan interested in contracting with a SMA include Medicaid only services in its bid?

Answer: For purposes of submitting bids to CMS, D-SNPs must include Part A, Part B, and Part D Medicare services in their PBPs, along with approved optional and mandatory supplemental benefits. A D-SNP may not include any Medicaid benefits paid by the SMA in its bid, in the PBP. For example, if a plan offers a preventive dental benefit for which the plan receives revenue from the SMA, that benefit must not be included in the plan's PBP.

²⁸ "General Provisions," 42 C.F.R. § 422.503(b)(4)(vi)(F) and (G)

²⁹ MMCM, chap. 16b, § 40.5.1

MA organizations are required to attest in the PBP that the additional supplemental benefit or benefits that the SNP provides do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid Plan, Medicare Part A or Part B, or if appropriate, Medicare Part D. This approach is necessary so that CMS can appropriately account for the Medicare benefit package and costs to the Medicare program.³⁰

Question: What is the State’s responsibility in reviewing care management and coordination of care for duals in SNPs if that State is operating under a limited contract with an MCO plan?

Answer: For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from an MA plan, the State determines to what extent the MCO must meet the primary care coordination, identification, assessment, and treatment planning with respect to dually eligible individuals. The State bases its determination on the services it requires the MCO to furnish to dually eligible enrollees.³¹

Question: Are States required to provide a listing of Medicaid providers to all MA plans?

Answer: States are not required to provide a listing of Medicaid providers to MA plans; however, the MA plan can survey its providers to identify which ones participate in Medicaid. This situation is different for D-SNPs, where one of the contract requirements, MIPPA element five, obliges SMAs to share information on providers that accept Medicaid and providers that participate in the D-SNP.³²

IV. STATE MEDICAID AGENCY CONTRACT DESIGN

Question: Where can I find the SMA Upload Document?

Answer: The SMA Upload Document can be found in HPMS, an automated system that is accessed and used by MA organizations as well as D-SNPs. The D-SNP is responsible for completing the SMA Upload Document.

The subsequent steps should be followed to download the SMA Upload Document:

- Go to the HPMS Home Page>Contract Management>Basic Contract Management>Select Contract Number>Submit Application Data;
- Download the links for the D-SNP State contract attestation, the upload section, and the SNP download file, which contains all the templates and readme files.

Question: What data do the States and MA organizations need to share with each another? What services must the MA organization provide?

Answer: CMS requires States and MA organizations to share sufficient data with each other to allow for the coordination and/or integration of Medicare and Medicaid benefits. CMS expects that these communications will include information on the providers participating in Medicaid, as well as providers in the D-SNP’s provider network.

³⁰CMS expects MA organizations to communicate MA and State Medicaid benefits to D-SNP beneficiaries in a comprehensive and transparent manner. For further guidance, see CMS, “Contract Year 2014 Medicare Advantage Bid Review and Operations Guidance”, April 17, 2013. Under the MA disclosure requirements (at 42 C.F.R. § 422.111[b][2][iii]), D-SNPs must furnish their enrollees with a comprehensive description of the Medicaid benefits and cost sharing that are available to them in marketing materials prior to enrollment.

³¹ “Coordination and Continuity of Care,” 42 C.F.R. § 438.208(a)(3)

³² MMCM, chap. 16b, § 40.5.1

Question: Will the SMA Contract MIPPA elements change from year to year?

Answer: No, the SMA contract MIPPA elements will not change annually. They are based on the regulations authorizing contracting requirements.³³ Specifically, the contract must document the following eight MIPPA elements:

1. The MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits;
2. The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under by the Social Security Act at sections 1902(a), 1902(f), 1902(p), and 1905;
3. The Medicaid benefits covered under the SNP;
4. The cost-sharing protections covered under the SNP;
5. The identification and sharing of information on Medicaid provider participation;
6. The verification of enrollee's eligibility for both Medicare and Medicaid;
7. The service area covered by the SNP; and
8. The contract period for the SNP.

Question: If States choose not to include a Medicaid service provision in the contract, do the States still need to share Medicaid provider information?

Answer: States that choose to negotiate and award contracts to MA organizations for D-SNPs must describe in the contract a process for the State to identify and share information on providers contracted with the SMA, regardless of the level of Medicaid services provided by the D-SNP. The State is under no obligation to monitor the degree to which the MA organization incorporates Medicaid providers into its D-SNP provider directory. However, CMS encourages such an arrangement to facilitate a collaborative effort to provide services to dual eligible beneficiaries.

Question: Does directing beneficiaries to call their Medicaid MCO qualify as meeting MIPPA Element 1 to “provide or arrange” for Medicaid services?

Answer: Directing enrollees to call their Medicaid MCO or to visit a website does not meet the requirements for MIPPA Element 1. CMS recognizes that in limited circumstances, dual eligible beneficiaries may receive Medicaid benefits through a Medicaid managed care contractor that is a separate entity from the MA organization offering the D-SNP. In these cases, the D-SNP must provide coordination of services or case management that result in coordination of Medicare and Medicaid benefits for the dual eligible enrollee. Regardless of the extent of Medicaid services provided by the D-SNP, any contract between a State and an MA organization must explicitly describe how coordination will occur to ensure that enrollees receive all the Medicare and Medicaid benefits to which they are entitled.

Question: What type of shared information on members who need services would the State need to make available?

Answer: The State should agree to a process for the D-SNP to verify an enrollee's Medicaid eligibility status, as required under MIPPA element six. Also, States are required, under MIPPA element five, to share information with the D-SNP to identify which providers accept Medicaid.³⁴ The D-SNP network (for Medicare and Medicaid) must meet the needs of the special needs population.

³³ “Special Needs Plans and Dual Eligibles: Contract with State Medicaid Agency”, 42 CFR § 422.107(c)

³⁴ MMCM, chap. 16b, § 40.5.1

V. STATE MEDICAID AGENCY CONTRACT SUBMISSION

Question: If an agreement between an MA organization and a State cannot be reached by the annual contract submission deadline, will CMS grant an extension?

Answer: No, CMS will not grant extensions; all contracts are due by July 1 of year preceding the contract year. For example, for CY2015, contracts must be submitted by July 1, 2014.

Question: What are the required upload documents for HPMS?

Answer: MA organizations operating D-SNPs are required to submit and upload the SMA contract and matrix to HPMS by July 1. After July 1, CMS will begin reviewing D-SNP SMA contract and matrix documents. If any MIPPA elements are not met, the D-SNP will receive a deficiency letter. CMS will permit a 30-day cure period for the D-SNP to correct any deficiencies. If a D-SNP wishes to be considered for FIDE SNP status, then the D-SNP should also upload the FIDE SNP matrix upload document.

Question: Are MA organizations required to reach out to the States to fix their deficiencies?

Answer: MA organizations should reach out to the State immediately upon receipt of the deficiency letter to begin addressing any deficiencies. CMS only permits 30 days to cure any deficiencies.

VI. FULLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLANS

Question: What is a FIDE SNP and what criteria must a D-SNP meet to be considered a FIDE SNP?

Answer: FIDE SNPs are D-SNPs that meet the following five elements:

1. Enrolls special needs individuals entitled to medical assistance under a Medicaid State plan;
2. Provides dual eligible beneficiaries access to Medicare and Medicaid benefits under a single MCO;
3. Has a CMS approved MIPPA compliant contract with a SMA that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk based financing;
4. 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
5. Employs policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.³⁵

Further, Section 1853(a)(1)(B) of the Act provides the authority to apply a frailty payment under Program of All-Inclusive Care for the Elderly (PACE) payment rules if a SNP meets the five elements to be considered a FIDE SNP and has similar average levels of frailty as PACE organizations.³⁶ CMS announces its methodology for determining whether a FIDE SNP has a

³⁵ As defined in section 1859(b)(6)(B)(ii) of the Social Security Act and 42 C.F.R. § 422.2, and the MMCM Chap. 16b, § 40.4.3

³⁶ In addition to Section 1853(a)(1)(B) of the Act, please also refer to MMCM Chap. 16b, § 30.2

similar average level of frailty as the PACE program annually.³⁷ 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 can demonstrate 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
- The plan must remain responsible for managing all benefits, including any carved-out service benefits, notwithstanding the method of payment (e.g., FFS, separate capitated rate) received by the plan.³⁸

Since the criteria can change annually, please refer to the most recent version of the Call Letter.

Question: Who performs the FIDE SNP reviews?

Answer: CMS ROs perform the FIDE SNP reviews, which consist of a review of the PBPs in response to requests for FIDE SNP consideration. The CMS CO then conducts a consistency review to ensure accuracy of RO review results.

VII. FINANCIAL ALIGNMENT DEMONSTRATION

Question: What is a Medicare-Medicaid Plan or “MMP”?

Answer: A Medicare-Medicaid Plan (MMP) is a private health plan that has been competitively selected and approved to provide integrated care to eligible full-benefit Medicare-Medicaid enrollees under the CMS Financial Alignment Demonstration.³⁹

Question: What is the Financial Alignment Demonstration?

Answer: The Financial Alignment Demonstration (Demonstration) is a CMS initiative that tests two models for States to better align Medicare and Medicaid financing and to integrate primary, acute, behavioral health, and long term services and supports for Medicare-Medicaid enrollees. The two models are as follows:

- **Capitated Model:** A State, CMS, and an MMP enter into a three-way contract, and the MMP receives a prospective blended payment to provide comprehensive, coordinated care.
- **Managed FFS Model:** A State and CMS enter into an agreement by which the State would be eligible to benefit from savings. These savings may result from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

³⁷ 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.

³⁸ MMCM Chap. 16b, § 40.4.3

³⁹ CMS, “Financial Alignment Initiative,” <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

Under either the Capitated Model or the Managed FFS Model, the State, CMS, and MMPs will share any savings that result from the financial alignment and integrated health services of the MMP. MMPs participating in a capitated Demonstration must sign a contract also signed by CMS and the State. An MMP's participation in the Demonstration formally begins once the three-way contract is signed by all parties and the MMP has passed a readiness review conducted by CMS.

Question: What must a State do in order to participate in the Financial Alignment Demonstration?

Answer: A State must complete a multi-phase approval process to participate in the Demonstration. There are three critical steps for approval:

1. Proposal – To participate in the Demonstration, a State must submit a proposal outlining its proposed approach. Proposals are evaluated against standards and conditions that CMS requires of all States seeking to participate in the Demonstration.⁴⁰
2. Memorandum of Understanding (MOU) – Once a State has met the standards and conditions of the Demonstration, CMS and the State develop an MOU. State-specific Demonstration parameters are delineated in the MOU.⁴¹
3. Three-Way Contract – A State must sign a contract also signed by CMS and any health plan selected to provide integrated care to eligible Medicare-Medicaid enrollees as a part of the Demonstration. It is important to note that a health plan's participation in the Demonstration formally begins once a contract is signed by all parties, and the health plan has passed the readiness review. CMS and participating States will ensure that all health plans selected to participate in the Demonstration are ready to accept enrollments, provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers, and fully meet the diverse needs of the dual eligible population.⁴²

Question: How is an MMP different from a D-SNP?

Answer: While both D-SNPs and MMPs are designed to provide integration and coordination of Medicare and Medicaid benefits for dual eligibles, there are five important distinctions, which are highlighted below:

1. D-SNPS – Plans that meet the eight MIPPA elements can operate in any State in which they have a contract with the SMA.
MMPs – Plans will operate only in select counties within demonstration States that have completed a three-step CMS approval process culminating in a three-way contract among CMS, the State, and the MMP. CMS and the State will work collaboratively to ensure MMPs comply with State-specific parameters.

⁴⁰ For additional information on the proposal process, go to <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

⁴¹ Sample MOUs can be found here: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>

⁴² <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>

2. **D-SNPs** – A variety of payment arrangements exist. For example, D-SNPs and States can enter into a capitated arrangement under which the State pays the plan prospectively per dual eligible enrollee per month for certain benefits. D-SNPs also can be compensated on a FFS basis or enter into premium or cost sharing arrangements with the State.
MMPs – Under the three-way contracts, all MMPs receive a prospective blended payment for providing integrated Medicare and Medicaid services. Payment rates are established to increase the quality of services through better integration and coordination of care while also providing CMS and the State with up-front cost savings. There is also an option for the State and CMS to enter into an FFS agreement that does not involve the MMP. Under those agreements, the State is eligible to benefit from savings achieved through initiatives that improve quality and reduce costs for Medicare and Medicaid.
3. **D-SNPs** – Serve both full and partial benefit dual eligibles.
MMPs – Serve only full benefit dual eligibles. Other limitations may apply. For example, in the State of Massachusetts, only individuals ages 21 to 64 enrolled in Medicare Parts A and B and also eligible for Medicare Part D and MassHealth Standard (Medicaid) can participate in a demonstration plan.
4. **D-SNPs** – For a type of SNP called a FIDE SNP, financial incentives are offered in the form of a frailty payment. Section 1853(a)(1)(B) of MIPPA authorizes inclusion of a frailty in the payment rules for plans under PACE. A D-SNP that meets the five elements of FIDE SNP and has enrollees with similar levels of frailty as PACE organizations, are also eligible for frailty payments.
MMPs – Are not eligible to receive frailty payments.
5. **D-SNPs** – No passive enrollment by States.
MMPs – States are permitted to passively enroll beneficiaries into MMPs with CMS approval. Under a mandated stipulation in the Demonstration, individuals may decline passive enrollment into an MMP and retain their existing coverage or may elect a different MMP from the one in which they were passively enrolled by the State.⁴³

Question: Can an organization that currently offers D-SNPs participate in the Demonstration?

Answer: CMS and States are interested in working with organizations (including D-SNPs) in the Demonstration that have previous experience delivering care to Medicare-Medicaid enrollees. However, any organization seeking to participate in the Demonstration will be required to meet CMS and State plan selection requirements.

Question: Can D-SNPs and MMPs operate in the same State?

Answer: D-SNPs and MMPs may operate in the same State and service area. Furthermore, parent organizations that offer D-SNPs can also offer MMPs provided the plans meet all relevant requirements.

⁴³ CMS does not limit the use of the term “passive enrollment” to the definition in 42 CFR § 422.60(g) and in MMCM, chap. 2, § 20.4.2. The model used here is being implemented under the authority of section 1115A of the Social Security Act. Section 1115A(d)(1) permits the Secretary to waive such requirements of Titles XE and XVIII and of sections 1902(a)(1), 1902(a)(3) and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out Section 1115A with respect to testing models described in section 1115A(b).

However, the operation of D-SNPs and MMPs in the same service areas is at the discretion of the State. States have the discretion to choose to contract with D-SNPs.

Question: If a State is considering passive enrollment, are there criteria that will allow certain beneficiaries to stay in their current plan?

Answer: Passive enrollment can be requested by a State for approval by CMS. Upon CMS approval, passive enrollment parameters will be determined based on the specifics of State requests. Beneficiaries can decline enrollment in an MMP and remain in their existing coverage. Furthermore, options do exist for beneficiaries enrolled in certain plans that also offer demonstration plans to be transitioned to the same organization's MMP.

Question: May States limit the Demonstration to only one plan that all full dual eligibles must join to receive Medicare and Medicaid benefits?

Answer: Generally, States proposing to conduct passive enrollment will need to have a minimum of two MMPs available in order to preserve beneficiary choice consistent with Medicaid rules. If a State already has a Medicaid waiver/exception to operate only one plan, such as in a rural area of the State, CMS will honor that waiver/exception.

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