DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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TO: Medicare Advantage Organizations with a Dual Eligible Special Needs Plan

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SUBJECT: Medicare Managed Care Manual Chapter 16-B: Special Needs Plans: Updates to State Medicaid Agency Contracts

The purpose of this memorandum is to share updates to section 20.2.2 and 20.2.3 of Chapter 16-B of the Medicare Managed Care Manual on the requirement for dual eligible special needs plans (D-SNPs) to have contracts with state Medicaid agencies under section 1859(f)(3)(D) of the Social Security Act and 42 CFR 422.107.

The updated section reflects current regulatory requirements in light of recent rulemaking. Where there are differences between statute or regulations and the manual, the statute or regulations control over the manual (and any other guidance). Therefore, interested parties should consult the applicable statutes, regulations, and final rules.

Chapter 16-B, incorporating the updated section, is available at the following link: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf. The updates for this section are also in Attachment A.

Please email MMCO at MMCO_DSNPOperations@cms.hhs.gov and your CMS Account Manager with any questions.

Attachment A – Updates to 20.2.2 and 20.2.3

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20.2.2 – State Contract Requirements for D-SNPs

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*S*ection 164(c)(2) of MIPPA, and as amended by section 3205(d) of the ACA, *requires that* all D-SNPs have an executed contract with applicable *s*tate Medicaid *a*gencies *beginning January 1, 2013*. See section 1859(f)(3)(D) of the Act *and implementing regulations at 42 CFR 422.107*.

The *Medicare Advantage Dual Eligible Special Need Plans A*pplication, which is available through HPMS *and on the CMS website*, provides further information on how and when D-SNPs must submit their *s*tate Medicaid *a*gency *c*ontracts (SMACs) and related information to CMS.

CMS requires each D-SNP to submit a SMAC for review by the first Monday in July every year for each state in which it seeks to operate for the upcoming contract year. A D-SNP with an evergreen SMAC is still required to submit its contract to CMS by the first Monday in July.

The SMAC must document each entity's roles and responsibilities with regard to dual*ly* eligible *individuals*, and must cover the minimum regulatory requirements below:

1. **The MAO's responsibilit*y to coordinate the delivery of, and if applicable*, provide *coverage of* Medicaid *services*. *(42 CFR 422.107(c)(1))***

   The SMAC must document the MAO's responsibility to coordinate the delivery of Medicaid benefits for individuals who are eligible for such services and, if applicable, provide coverage of Medicaid benefits, including long-term services and supports and behavioral health services, for individuals eligible for such services.

2. **The categories of eligibility for dual*ly* eligible *individuals* to be enrolled under the D-SNP. *(42 CFR 422.107(c)(2))***

   The SMAC must clearly identify the dual*ly* eligible population*s* that *are* eligible to enroll in the D-SNP. A D-SNP may only enroll dual*ly* eligible *individuals* as specified in the SMAC. *If a SMAC states that a D-SNP can only enroll* certain dual*ly* eligible *individuals* (e.g., *full-benefit dually eligible individuals,* those aged 65 and above), the MAO *must limit its D-SNP enrollment accordingly.*

3. **The Medicaid benefits covered under the D-SNP. *(42 CFR 422.107(c)(3))***

   The SMAC must include information on plan benefit design, benefit administration, and assignment of responsibility for providing, or arranging for, the covered benefits. The contract must *document* the *Medicaid* benefits *covered under a capitated contract, as applicable, between the state Medicaid agency and the MAO offering the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization*. If the list of services is an attachment to the contract, the *D-*SNP must reference the list in the body of the contract.

4. **The cost sharing protections covered under the D-SNP. *(42 CFR 422.107(c)(4))***

The SMAC must require that D-SNPs not impose cost sharing on specified dual*ly* eligible *individuals* (i.e., *f*ull-*benefit dually eligible* individuals, QMBs, or any other population designated by the state) that exceed*s* the amount *that would be* permitted under the *s*tate Medicaid plan if the individual were not enrolled in the D-SNP. In addition, the D-SNP must meet all MA maximum out-of-pocket (MOOP) requirements*, as described in section 20.2.4.1 of this chapter*.

5. **The identification and sharing of information *on* Medicaid provider participation. *(42 CFR 422.107(c)(5))***

The SMAC must enumerate *a process for* how the state will identify and share information about providers contracted with the *s*tate Medicaid *a*gency so that they may be included in the *D-*SNP *'s* provider directory. Although CMS does not require all providers to accept both Medicare and Medicaid, the D-SNP's network must meet the needs of the dual*ly* eligible population served.

6. **The verification process of an enrollee's eligibility for Medicaid. *(42 CFR 422.107(c)(6))***

The SMAC must require that MAOs receive access to information verifying eligibility of dual*ly* eligible enrollees from the *s*tate Medicaid *a*gency. The *SMAC must describe how* the D-SNP and the state *exchange information to verify each enrollee's Medicaid eligibility*.

7. **The service area covered under the SNP. *(42 CFR 422.107(c)(7))***

The SMAC must identify the service areas *for* which the state has agreed the MAO may *offer (i.e.,* market and enroll *beneficiaries in) one or more D-SNPs*. The D-SNP service area(s) must be consistent with the SMAC-approved service area(s).

8. **The contract period. *(42 CFR 422.107(c)(8))***

The SMAC must require a period of performance between the *s*tate Medicaid *a*gency and the D-SNP of at least January 1 through December 31 of the year following the due date of the contract. Contracts also may be drafted as multi-year, or "evergreen" contracts (i.e., continuously valid until a change is made in the contract), as long as the entire calendar year is covered.

9. Unified appeals and grievances. (42 CFR 422.107(c)(9))

For D-SNPs that meet the definition of an applicable integrated plan as defined in 42 CFR 422.561, the SMAC must require documentation of the use of unified appeals and grievance procedures under 42 CFR 422.629 through 422.634, 438.210, 438.400, and 438.402.

10. Minimum integration requirement. (42 CFR 422.107(d))

10a. Hospital and skilled nursing facility data notification requirements. (42 CFR 422.107(d)(1))

The SMAC requires any D-SNP that is not a fully integrated or highly integrated D-SNP (as defined in 422.2), except as specified at 42 CFR 422.107(d)(2) (which is described in section 10b below), to notify, or arrange for another entity or entities to notify, the state Medicaid agency, individuals or entities designated by the state Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the state Medicaid agency. The SMAC must establish the timeframe(s) and method(s) by which notice is provided. In the event that a D-SNP authorizes another entity or entities to perform this notification, the D-SNP must retain responsibility for complying with the requirement in 42 CFR 422.107(d)(1).

10b. Exception to hospital and SNF data notification requirements for certain D-SNPs (42 CFR 422.107(d)(2))

The SMAC requirement at 42 CFR 422.107(d)(1) (which is described in section 10a) does not apply to a D-SNP that meets two conditions:

(1) Under the terms of its SMAC, the D-SNP only enrolls beneficiaries who are not entitled to full medical assistance under a state plan under title XIX of the Act (i.e., partial-benefit dually eligible individuals); and

(2) The D-SNP operates under the same parent organization and in the same service area as a D-SNP limited to beneficiaries with full medical assistance under a state plan under title XIX of the Act (i.e., full-benefit dually eligible individuals) that meets the requirements under 42 CFR 422.107(d)(1).

20.2.3 – Relationship to State Medicaid Agencies *(42 CFR 422.107(b))*

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Pursuant to section *164(c)(4) of MIPPA*, *s*tate Medicaid *a*gencies are not required to enter into

contracts with MAOs with respect to *D*-SNP*s*. *In addition to the SMAC,* the MAO must still meet all CMS application requirements, includ*ing that the organization be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in the state, to have an MA contract and to offer a D-SNP*.