CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 126 **Date: March 31, 2023**

SUBJECT: Update to Section 20.2.4.1 on Special Cost Sharing Requirements for D-SNPs

I. SUMMARY OF CHANGES: The updated section now better reflects current regulatory requirements in light of the recent Contract Year 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F). Changes are as follows:

- We added language to clarify MAOs that are DSNPs must comply with and ensure their contractor providers comply with limits on out-of-pocket costs for dually eligible individuals (SOURCE)
- We removed content on States and MAOs regarding Medicaid benefits and contract negotiations as (1) it does not match recent preamble discussion or 422.107, and (2) it is not directly germane to the subject addressed in this section of the manual (cost sharing).
- We removed reference to Part D cost sharing since states can only cover with state-only dollars, not Medicaid funding. We also revised so it does not say "hold harmless" which is inaccurate and used "covered" to characterize the state role related to cost sharing, since states often do not actually make a payment.
- We made edits regarding MAO responsibility to tracking OOP spending and notifying enrollees and contracted providers when the MOOP limit is attained, consistency with regulatory language (at CFR 27859).
- We provided updated language and deleted old, no longer accurate information regarding what costs count towards the MOOP limit, consistent with the CY 2023 Medicare Advantage and Part D Final Rule.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: 1/1/2023
IMPLEMENTATION DATE: 1/1/2023

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	16B/20.2.4.1 – Special Cost Sharing Requirements for D-SNPs/General

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Medicare Managed Care Manual
Chapter 16-B: Special Needs Plans

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(Rev. 123, Issued: 08-19-16)

10 – Introduction

10.1 – General

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

This chapter reflects the Centers for Medicare & Medicaid Services' (CMS) current interpretation of statute and regulation that pertains to Medicare Advantage (MA) coordinated care plans (CCPs) for special needs individuals, referred to hereinafter as special needs plans (SNPs). This manual chapter is a subchapter of chapter 16, which categorizes guidance that pertains to specific types of MA plans, such as private fee-for-service (PFFS) plans. The contents of this chapter are generally limited to the statutory framework set forth in title XVIII, sections 1851-1859 of the Social Security Act (the Act), and are governed by regulations set forth in chapter 42, part 422 of the Code of Federal Regulations (CFR) (42 CFR 422.1 et seq.). This chapter also references other chapters of the Medicare Managed Care Manual (MMCM) that pertain to enrollment, benefits, marketing, and payment guidance related to special needs individuals.

To assist MA organizations (MAOs) in distinguishing the requirements that apply to SNPs, Table 1 below provides information on the applicability in sections of this chapter to each specific type of SNP, that is, chronic condition SNP (C-SNP), dual eligible SNP (D-SNP), and institutional SNP (I-SNP), as described in section 20 of this chapter.

Table 1: Chapter Sections Applicable to Certain SNP Types

SNP Type	Applicable Sections
C-SNP	20.1; 40.2.1; 50.3
D-SNP	20.2; 30.4; 40.2.2; 40.4; 50.2; 50.3
I-SNP	20.3; 40.2.3; 40.6; 50.3

10.2 – Statutory and Regulatory History

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

The Medicare Modernization Act of 2003 (MMA) established an MA CCP specifically designed to provide targeted care to individuals with special needs. In the MMA, Congress identified "special needs individuals" as: 1) institutionalized individuals; 2) dual eligibles; and/or 3) individuals with severe or disabling chronic conditions, as specified by CMS. MA CCPs established to provide services to these special needs individuals are called "Specialized MA plans for Special Needs Individuals," or SNPs. 42 CFR 422.2 defines special needs individuals and specialized MA plans for special needs individuals. SNPs were first offered in 2006. The MMA gave the SNP program the authority to operate until December 31, 2008.

The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 subsequently extended the SNP program from December 31,

2008, to December 31, 2009, but imposed a moratorium that prohibited CMS from approving new SNPs after January 1, 2008. Accordingly, CMS did not accept SNP applications in 2008 for contract year (CY) 2009.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) lifted the Medicare, Medicaid, and SCHIP Extension Act of 2007 moratorium on approving new SNPs. MIPPA further extended the SNP program through December 31, 2010, thereby allowing CMS to accept MA applications for new SNPs and SNP service area expansions until CY 2010. CMS accepted SNP applications from MA applicants for creating new SNPs and expanding existing CMS-approved SNPs for all three types of specialized SNPs in accordance with additional SNP program requirements specified in MIPPA. CMS regulations that implement and further detail MIPPA application requirements for SNPs are located at 42 CFR 422.501-504.

Effective immediately upon its enactment in 2011, section 3205 of the Patient Protection and Affordable Care Act ("ACA") extended the SNP program through December 31, 2013, and mandated further SNP program changes as outlined below. Section 607 of the American Taxpayer Relief Act of 2012 (ATRA) extended the SNP program through December 31, 2014. Section 1107 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) extended the SNP program through December 31, 2015. Section 107 of the Protecting Access to Medicare Act of 2014 extended the SNP program through December 31, 2016. Most recently, section 206 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018.

Section 3205 of the ACA amended sections 1859(f)(7), 1853(a)(1)(B)(iv), and 1853(a)(1)(C)(iii) of the Act to:

- Require all SNPs to be approved by the National Committee for Quality Assurance (NCQA) (based on standards established by the Secretary) (see section 30.2 of this chapter);

- Authorize CMS to apply a frailty adjustment payment for Fully Integrated Dual Eligible (FIDE) SNPs (see section 20.2.5.1 of this chapter); and

- Improve risk adjustment for special needs individuals with chronic health conditions (see section 20.1.4 of this chapter).

10.3 – Requirements and Payment Procedures

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

SNPs are expected to follow existing MA program rules, including MA regulations at 42 CFR 422, as interpreted by guidance, with regard to Medicare-covered services and Prescription Drug Benefit program rules. All SNPs must provide Part D prescription drug coverage because special needs individuals must have access to prescription drugs to manage and control their special health care needs (see 42 CFR 422.2). SNPs should assume that existing Part C and D rules apply unless there is a specific exception in the

regulation/statutory text or other guidance to CMS interpreting the rule as not applicable to SNPs. Additional requirements for SNP plans can be found in the Prescription Drug Benefit Manual at: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html.

Payment procedures for SNPs mirror the procedures that CMS uses to make payments to non-SNP MA plans. SNPs must prepare and submit bids like other MA plans, and are paid in the same manner as other MA plans based on the plan's enrollment and the risk adjustment payment methodology. Guidance on payment to MAOs is available in chapter 8 of the MMCM. CMS posts current MA payment rates online in the "Ratebooks & Supporting Data" section at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

Current CMS guidance on cost sharing requirements, including guidance provided by the CMS model marketing materials at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html, is applicable to all SNPs.

20 – Description of SNP Types
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

SNPs may be any type of MA CCP, including either a local or regional preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan, as described in chapter 1 of the MMCM. This section describes the three types of SNPs (i.e., C-SNPs, D-SNPs, and I-SNPs) in further detail.

20.1 – Chronic Condition SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

20.1.1 – General
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. Approximately two-thirds of Medicare enrollees 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.

A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all CCPs, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs. (See section 60 below and the Medicare Marketing Guidelines at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html, for more information on SNP-specific marketing).

20.1.2 – List of Chronic Conditions

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Section 1859(b)(6)(B)(iii) of the Act and 42 CFR 422.2 define special needs individuals with severe or disabling chronic conditions as special needs 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." CMS solicited public comments on chronic conditions meeting the clarified definition and convened the SNP Chronic Condition Panel in the fall of 2008. Panelists included six clinical experts on chronic condition management from three federal agencies—the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and CMS. After discussing public comments on a proposed list of SNP-specific chronic conditions, the panelists recommended, and CMS subsequently approved, the following 15 SNP-specific chronic conditions:

1. Chronic alcohol and other drug dependence;

2. Autoimmune disorders limited to:

    - Polyarteritis nodosa,
    - Polymyalgia rheumatica,
    - Polymyositis,
    - Rheumatoid arthritis, and
    - 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, and
    - Chronic venous thromboembolic disorder;

5. Chronic heart failure;

6. Dementia;

7. Diabetes mellitus;

8. End-stage liver disease;

9. End-stage renal disease (ESRD) requiring dialysis;

10. Severe hematologic disorders limited to:

    - Aplastic anemia,
    - Hemophilia,
    - Immune thrombocytopenic purpura,
    - Myelodysplatic syndrome,
    - Sickle-cell disease (excluding sickle-cell trait), and
    - Chronic venous thromboembolic disorder;

11. HIV/AIDS;

12. Chronic lung disorders limited to:

    - Asthma,
    - Chronic bronchitis,
    - Emphysema,
    - Pulmonary fibrosis, and
    - Pulmonary hypertension;

13. Chronic and disabling mental health conditions limited to:

    - Bipolar disorders,
    - Major depressive disorders,
    - Paranoid disorder,
    - Schizophrenia, and
    - 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, and
    - Stroke-related neurologic deficit; and

15. Stroke.

The list of SNP-specific chronic conditions is not intended for purposes other than clarifying eligibility for the C-SNP CCP benefit package. CMS may periodically re-evaluate the fifteen 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.

20.1.3 – Grouping Chronic Conditions
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

When completing the SNP application, MAOs may apply to offer a C-SNP that targets any one of the following:

1. A single CMS-approved chronic condition (selected from the list in section 20.1.2 above),

2. A CMS-approved group of commonly co-morbid and clinically-linked conditions (described in section 20.1.3.1 below), or

3. An MAO-customized group of multiple chronic conditions (described in section 20.1.3.2 below).

20.1.3.1 – CMS-Approved Group of Commonly Co-Morbid and Clinically-Linked Conditions
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

A C-SNP may not be structured around multiple commonly co-morbid conditions that are not clinically linked in their treatment because such an arrangement results in a general market product rather than one that is tailored for a particular population. C-SNPs are permitted to target a group of commonly co-morbid and clinically linked chronic conditions. Based on CMS's data analysis and recognized national guidelines, CMS identified five combinations of commonly co-existing chronic conditions that may be the focus of a C-SNP.

CMS accepts applications for C-SNPs that focus on the following five 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.

For MAOs that are approved to offer a C-SNP targeting one of the above-listed groups, enrollees need to have only one of the qualifying conditions for enrollment. CMS will review the Model of Care (MOC) and benefits package for the multi-condition C-SNP to

determine adequacy in terms of creating a specialized product for the chronic conditions it serves.

20.1.3.2 – MAO-Customized Group of Multiple Chronic Conditions
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

MAOs may develop their own multi-condition C-SNPs for enrollees who have all of the qualifying commonly co-morbid and clinically linked chronic conditions in the MAO's specific combination. MAOs that pursue this customized option must verify that enrollees have all of the qualifying conditions in the combination. MAOs interested in pursuing this option for multi-condition C-SNPs are limited to groupings of the same 15 conditions selected by the panel of clinical advisors that other C-SNPs must select. As with SNPs pursuing the Commonly Co-Morbid and Clinically-Linked Option described in section 20.1.3.1, CMS will carefully assess the prospective multi-condition SNP application to determine the adequacy of its care management system for each condition in the combination and will review the MOC and benefits package.

20.1.4 – Hierarchical Condition Categories Risk Adjustment for C-SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

CMS uses a risk score that reflects the known underlying risk profile and chronic health status of similar individuals for purposes of hierarchical condition categories (HCC) risk adjustment described under section 1853(a)(1)(C) of the Act. The Act requires CMS to use such risk score in place of the default risk score that is otherwise used to determine payment for new enrollees in MA plans. For a description of any evaluation conducted during the preceding year and any revisions made under section 1853(b) of the Act, refer to CMS's annual "Announcement of Calendar Year Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" ("Announcement"), located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

20.2 – Dual Eligible SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

20.2.1 – General
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

D-SNPs enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility. The Medicaid eligibility categories encompass all categories of Medicaid eligibility including:

- Full Medicaid (only);
- Qualified Medicare Beneficiary without other Medicaid (QMB Only);

- QMB Plus;
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only);
- SLMB Plus;
- Qualifying Individual (QI); and
- Qualified Disabled and Working Individual (QDWI).

States may vary in determining their eligibility categories; therefore, there may be state-specific differences in the eligibility levels in comparison to those listed here. For specific information regarding Medicaid eligibility categories, refer to: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html.

CMS no longer categorizes D-SNPs by subtype (see the December 7, 2015, HPMS memo "Discontinuation of Dual Eligible Special Needs Plans Sub-type Categories"). However, Table 2 below summarizes the dual eligible Medicaid programs ("Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs," Medicare Learning Network, February 2016).

Table 2: Dual Eligible Medicaid Programs

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits
Full Medicaid (only)	Determined by State	Determined by State	Not applicable (N/A)	In some cases, institutional status or clinical need may factor into eligibility	• Full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home- and community-

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits
					based waivers • Medicaid may pay for Part A (if any) and Part B premiums and cost sharing for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan
QMB Only	≤100% of Federal Poverty Line (FPL)	≤3 times Supplemental Security Income (SSI) resource limit, adjusted annually in accordance with increases in Consumer Price Index (CPI)	Part A***	N/A	• Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits
QMB Plus	≤100% of FPL	Determined by State	Part A***	Meets financial and other criteria for full Medicaid benefits	• Full Medicaid coverage • Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)
SLMB Only	>100% of FPL but <120% of FPL	≤3 times SSI resource limit, adjusted annually in accordance with increases in CPI	Part A	N/A	• Medicaid pays for Part B premiums
SLMB Plus	>100% of FPL but <120% of FPL	Determined by State	Part A***	Meets financial and other criteria for full Medicaid benefits	• Full Medicaid coverage • Medicaid pays for Part B premiums
QI**	≥120% of FPL but <135% of	≤3 times SSI resource limit,	Part A	N/A	• Medicaid pays for Part B premiums

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits
	FPL	adjusted annually in accordance with increases in CPI			
QDWI	≤200% of FPL	≤2 times SSI resource limit	Part A benefits lost due to individual's return to work; eligible to enroll in and purchase Part A coverage	N/A	• Medicaid pays for Part A premiums

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Social Security Act (the Act).
** Beneficiaries under this program are not otherwise eligible for full Medicaid coverage through the State.
*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the Social Security Administration (SSA) Program Operations Manual System at http://policy.ssa.gov/poms.nsf/lnx/0600801140 on the SSA website. To qualify as a SLMB, SLMB plus, or QI, individuals must be enrolled in Part A. Part A coverage is not a factor for full Medicaid eligibility.

20.2.2 – State Contract Requirements for D-SNPs

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

As provided under section 164(c)(2) of MIPPA, and as amended by section 3205(d) of the ACA, as of January 1, 2013, all D-SNPs are required to have an executed contract with applicable State Medicaid Agencies. See section 1859(f)(3)(D) of the Act.

The SNP application, which is available through HPMS, provides further information on how and when D-SNPs must submit their State Medicaid Agency Contracts (SMACs) and related information to CMS. Plans should refer to the "State Medicaid Agency Contract Upload Document" and other documents included in the online application page in HPMS.

The SMAC must document each entity's roles and responsibilities with regard to dual

eligibles, and must cover the minimum regulatory requirements below:

1. The MAO's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits.

   This contractual element requires the process by which the D-SNP agency provides and/or arranges for Medicaid benefits be clearly outlined in the contract between the State Medicaid Agency and the entity. All contracts must specify how the Medicare and Medicaid benefits are integrated and/or coordinated.

2. The categories of eligibility for dual eligibles to be enrolled under the D-SNP, including the targeting of specific subsets.

   This contractual element requires the contract to clearly identify the dual-eligible population that is eligible to enroll in the D-SNP. A D-SNP may only enroll dual eligibles as specified in the SMAC. For example, if a State Medicaid Agency contracts with a plan for a Medicaid wraparound package for certain dual eligibles (e.g., those aged 65 and above), the MAO may establish a D-SNP that limits enrollment to that same subset of dual eligibles. For MAOs whose contract with the state is for Medicaid managed care, enrollment in a D-SNP offered by the organization must be limited to the same category of Medicaid dual eligibles as are permitted to enroll in that organization's Medicaid managed care contract.

3. The Medicaid benefits covered under the D-SNP.

   This contractual element requires information be included on plan benefit design, benefit administration, and assignment of responsibility for providing, or arranging for, the covered benefits. The contract must specify the benefits offered in the Medicaid State Plan, including any benefits that are not covered by original Medicare 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.

4. The cost sharing protections covered under the D-SNP.

   This contractual element requires that D-SNPs not impose cost sharing on specified dual eligibles (i.e., Full Medicaid individuals, QMBs, or any other population designated by the state) that exceed the amounts permitted under the State 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.

5. The identification and sharing of information about Medicaid provider participation.

   This contractual element requires that a process be enumerated regarding how

the state will identify and share information about providers contracted with the State Medicaid Agency so that they may be included in the SNP 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-eligible population served.

6. The verification process of an enrollee's eligibility for both Medicare and Medicaid.

   This contractual element requires that MAOs receive access to real-time information verifying eligibility of dual-eligible enrollees from the State Medicaid Agency. The agreed-upon eligibility verification process between the D-SNP and the state must be described in detail.

7. The service area covered under the SNP.

   This contractual element requires that the covered service area(s) in which the state has agreed the MAO may market and enroll, be clearly identified. The D-SNP service area(s) must be consistent with the SMAC-approved service area(s).

8. The contracting period.

   This contractual element requires a period of performance between the State Medicaid Agency 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.

CMS requires the D-SNP to submit a SMAC for review by July 1 every year. A D-SNP with an evergreen contract is still required to submit its contract to CMS by July 1 and must include a letter from the State Medicaid Agency stating that it intends to continue contracting with the MAO for the upcoming calendar year.

20.2.3 – Relationship to State Medicaid Agencies

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Pursuant to section 1859 of the Act, State Medicaid Agencies are not required to enter into contracts with MAOs with respect to a SNP. However, if the MAO does have such a contract, the MAO must still meet all CMS application requirements, to include securing a license and certification from the State Department of Insurance to offer an MA product in the state, among other requirements.

20.2.4 – Special Cost Sharing Requirements for D-SNPs

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

20.2.4.1 – General

(Rev.126, Issued:03-31-23, Effective:01-01-23, Implementation: 01-01-23)

MAOs offering D-SNPs *must comply with and ensure that their contracted providers comply with limits on out-of-pocket costs for dually eligible individuals.* Pursuant to section 1852(a)(7) of the Act and 42 CFR 422.504(g)(1)(iii), D-SNPs cannot impose cost sharing *for Medicare Parts A or B benefits on* specified *dually* eligible individuals (QMBs *and full-benefit Medicaid individuals*, or other *Medicaid populations when* the state *is responsible for covering such amounts*) that would exceed the amounts permitted under the State Medicaid Plan if the individual were not enrolled in the D-SNP. This category includes QMB *Only* and QMB *Plus*, the two categories of dual *eligibility* that have all Medicare Parts A and B cost sharing *covered* by Medicaid, and may also include other *dually* eligible enrollees *for whom* the state *covers* Part A *or* Part B cost sharing *(such as SLMB Plus)*.

Like all other local MA plans (per 42 CFR 422.100(f)(4)), D-SNPs must establish a MOOP *amount.* For purposes of tracking out-of-pocket spending relative to its MOOP *amount*, a plan must count *all costs for Medicare Parts A and B services accrued under the plan benefit package, including cost sharing paid by any applicable secondary or other coverage (such as through Medicaid, employer(s), and commercial insurance) and any cost sharing that remains unpaid (such as because of limits on Medicaid liability for Medicare cost sharing under the lesser-of policy and the cost sharing protections afforded certain dually eligible individuals). When these out-of-pocket costs for an enrollee reach the MOOP amount, the D-SNP is responsible for 100 percent of the costs of items and services covered under Parts A and B.*

D-SNPs (like all MA organizations) are responsible for tracking out-of-pocket spending accrued by each enrollee and must alert enrollees and contracted providers when the MOOP amount is reached (42 CFR 422.100(f)(4) and (f)(5)(iii), and 422.101(d)). Remittance advice or explanation of benefits notices issued per 42 CFR 422.111(k) that indicate attainment of the MOOP amount and the absence of any additional cost sharing charges may fulfill the notice requirement for providers and enrollees.

20.2.4.2 - D-SNPs With or Without Medicare Zero-Dollar Cost Sharing

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

At the time of plan creation, each D-SNP must identify whether or not if offers Medicare zero-dollar cost sharing. In HPMS, D-SNPs will have the option of one of the following two indicators:

1. Medicare Zero-Dollar Cost Sharing Plan, or

2. Medicare Non-Zero Dollar Cost Sharing Plan.

These two indicators will be used in multiple areas within HPMS and are essential to the proper display of benefits in Medicare Plan Finder.

20.2.4.3 – Cost Sharing for Dual Eligibles Requiring an Institutional Level of Care

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

As provided under section 1860D-14 of the Act, full-benefit dual eligible individuals who are institutionalized individuals have no cost sharing for covered Part D drugs under their Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug (MA-PD) Plan. As of January 1, 2012, section 1860D-14 of the Act also eliminates Part D cost sharing for Full Medicaid individuals who are receiving home and community-based services (HCBS) either through:

- A home and community-based waiver authorized for a state under section 1115 or subsection (c) or (d) of section 1915 of the Act;

- A Medicaid State Plan Amendment under section 1915(i) of the Act; or

- A Medicaid managed care organization with a contract under section 1903(m) or section 1932 of the Act.

These services target frail, elderly individuals who, without the delivery in their home of services such as personal care services, would be institutionalized. HCBS eligibility is not based on where an individual resides. In other words, SNPs cannot assume that all enrollees residing in assisted living facilities receive HCBS and therefore qualify for the zero-dollar cost sharing. Thus, in order to qualify for zero-dollar cost sharing, a SNP must determine or an enrollee must demonstrate that s/he is a full-benefit Medicaid individual receiving HCBS as stated above. Below, we list acceptable documents that SNPs may use as best available evidence for demonstrating receipt of HCBS:

- A copy of a state-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the enrollee's name and HCBS eligibility date during a month after June of the previous calendar year;

- A copy of a state-approved HCBS Service Plan that includes the enrollee's name and effective date beginning during a month after June of the previous calendar year;

- A copy of a state-issued prior authorization approval letter for HCBS that includes the enrollee's name and effective date beginning during a month after June of the previous calendar year; or

- Other documentation provided by the state showing HCBS eligibility status during a month after June of the previous calendar year.

20.2.5 – Fully Integrated Dual Eligible SNPs

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

A FIDE SNP is a D-SNP that is a Medicare and Medicaid fully integrated product. D-SNPs classified as FIDE are described in section 1853(a)(1)(B)(iv) of the Act and at 42 CFR 422.2. FIDE SNPs are CMS-approved D-SNPs that:

- Enroll special needs individuals entitled to medical assistance under a Medicaid State Plan, as defined in section 1859(b)(6)(B)(ii) of the Act and 42 CFR 422.2;

- Provide dual-eligible enrollees access to Medicare and Medicaid benefits under a single managed care organization;

- Have a CMS-approved, MIPPA-compliant contract with a State Medicaid Agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with state policy, under risk-based financing;

- Coordinate 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 enrollees; and

- Employ policies and procedures approved by CMS and the state to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement.

As stated in the April 2, 2012, "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" in determining whether a D-SNP meets the FIDE-SNP definition at 42 CFR 422.2, CMS will allow long-term care benefit carve-outs or exclusions only if the plan 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 (180 days) of the plan year;

- The enrollee must not be disenrolled from the plan as a result of exhausting the service 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., fee-for-service, separate capitated rate) received by the plan.

Additionally, notwithstanding any benefit carve-outs permitted under such an arrangement, D- SNPs in states that currently require capitation of long-term care benefits for a longer duration than this specified minimum must maintain this level of capitation.

20.2.5.1 – Application of Frailty Adjustment for FIDE SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Section 1853(a)(1)(B)(iv) of the Act gives the Secretary the authority to apply a frailty adjustment payment under the rules for Program of All-Inclusive Care for the Elderly (PACE) payment, for certain FIDE SNPs, to reflect the costs of treating high concentrations of frail individuals. CMS announces its methodology for determining whether a FIDE SNP "has a similar average level of frailty…as the PACE program" in its annual "Announcement," located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. Every fall, we also notify each FIDE SNP of its frailty score and of how it compares to PACE organizations.

Frailty scores are calculated using the limitation on activities of daily living (ADL) reported by a plan's enrollees, based on the Medicare Health Outcomes Survey (HOS) from the year previous to the payment year. For example, for payment year 2017, CMS will use the 2016 HOS or Health Outcomes Survey-Modified (HOS-M) to determine a frailty score for FIDE SNPS. MAOs that believe they will be sponsoring a FIDE SNP in 2017 and want to be considered for a frailty payment must participate in the 2016 HOS or HOS-M to allow for CMS to calculate their frailty score. For more information, please see the annual fall HPMS memo, "Participation in HOS for MA Organizations Planning to Sponsor FIDE SNPs."

Therefore, in order for a SNP to be eligible to receive frailty payments pursuant to section 1853 of the Act, the SNP must: (1) satisfy the FIDE SNP definition under 42 CFR 422.2(3); (2) participate in the HOS; and (3) have similar average levels of frailty as PACE organizations as described in the Advance Notice for the given year.

20.2.6 – Benefit Flexibility for Certain D-SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Regulations at 42 CFR 422.102(e) allow D-SNPs that meet a high standard of integration (although not necessarily as much integration as FIDE SNPs) and specified performance and quality-based standards to offer supplemental benefits beyond those currently permitted for MA plans. CMS has limited this benefit flexibility to qualified D-SNPs because CMS believes those plans are best positioned to achieve the objective of keeping dual-eligible enrollees who are at risk of institutionalization in the community.

20.2.6.1 – Benefit Flexibility Eligibility Requirements
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

In order to be eligible for benefit flexibility, the D-SNP must:

- Be a specialized MA plan for dual-eligible special needs individuals described in section 1859(b)(6)(B)(ii) of the Act.

- Be operational in the upcoming CY and have operated the entire previous CY.

- Possess a valid contract arrangement with the state, in accordance with CMS policy and the requirements at 42 CFR 422.107, that:

    - Includes coverage of specified primary, acute, and long-term care benefits and services to the extent capitated coverage is consistent with state policy; and

    - Coordinates delivery of covered Medicare and Medicaid primary, acute, and long-term care services throughout its entire service area, using aligned care management and specialty care network methods for high-risk enrollees.

- Have received a three-year approval of its MOC most recently reviewed by NCQA.

- Be part of a contract with a current three-star (or higher) overall rating on the Medicare Plan Finder website. Please note: If the D-SNP is part of a contract that does not have sufficient enrollment to generate a star rating, CMS will base the ratings on the most recent SNP plan-level Healthcare Effectiveness Data and Information Set (HEDIS) measures. The 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
    - Medication Reconciliation Post-Discharge.

- Not be part of a contract with a score of two (negative) points or more on either the Part C or the Part D portion of the previous application cycle past performance review methodology. The past performance methodology currently analyzes the performance of MA and Part D contracts in 11 distinct performance categories, assigning negative points to contracts with poor performance in each category. The analysis uses a 14-month look-back period.

20.2.6.2 – Characteristics and Categories of Flexible Supplemental

Benefits

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

CMS expects D-SNPs to use the flexibility to design their benefits in a way that adds value for the enrollee by augmenting and/or bridging a gap between Medicare and Medicaid covered services. CMS may approve flexible supplemental benefits that have the following characteristics:

- Are most appropriate for individuals who need assistance with ADLs, such as:
  - Eating, drinking, dressing, bathing, grooming, toileting, transferring, and mobility.

- Are most appropriate for individuals who need assistance with instrumental activities of daily living (IADLs), such as:
  - Transportation, grocery shopping, preparing food, financial management, and medication management.

- Must be provided to the enrollee at zero cost.

- Must not be duplicative of Medicaid, including the State Medicaid or local benefits for enrollees who are eligible to receive identical Medicaid services.

- Must not be duplicative of Medicare, including Medicare supplemental benefits (described in chapter 4 of the MMCM).

- Must be uniformly offered and available to all enrollees.

Table 3 below sets forth guidance on specific categories of flexible supplemental benefits that qualified D-SNPs may consider offering to those enrollees who do not already qualify for them under Medicaid.

Table 3: Flexible Supplemental Benefits for Consideration

Proposed Benefit Category	Benefit Description	Acceptable Means of Delivery	PBP Description
Non-Skilled In-Home Support Services	Non-skilled services and support services performed by a personal care attendant or by another individual that is providing these services consistent with state requirements in order to assist individuals with disabilities and/or chronic conditions with performing ADLs and IADLs as necessary to support recovery, to prevent decline following an acute illness, prevent exacerbation of a chronic condition, and/or to aid with functional limitations. This benefit category also includes non-medical transportation that assists in the performance of IADLs, but that goes beyond the transportation services supplemental benefit described in section 30.3 of chapter 4 of the MMCM.	Services would be performed by individuals licensed by the state to provide personal care services, or in a manner that is otherwise consistent with state requirements.	Describe the criteria the plan intends to use (e.g., level of care need, ADL limitations, etc.) to determine which enrollees are eligible for personal care services.

Proposed Benefit Category	Benefit Description	Acceptable Means of Delivery	PBP Description
In-Home Food Delivery	Meal delivery service (beyond the limited coverage described in chapter 4 of the MMCM) for individuals who cannot prepare their own food (IADL limitation) due to functional limitations with ADLs or short-term functional disability, or for individuals who, based on a physician's recommendation, require nutritional supplementation following an acute illness or resulting from a chronic condition.	Meals would be provided consistent with plan policies for ensuring nutritional content (i.e., minimum recommended daily nutritional requirements).	Describe the Medicare meal benefit comprehensively, and clearly distinguish meal benefits for individuals who would already qualify under current meal benefit guidance from meal benefits under an expanded definition. Describe any limits imposed on meal benefits (e.g., duration, criteria for eligibility,
Supports for Caregivers of Enrollees	Provision of respite care—either through a personal care attendant or through provision of short-term institutional-based care—for caregivers of enrollees. Coverage may include benefits such as counseling and training courses (related to the provision of plan-covered benefits) for caregivers of enrollees.	Specific caregiver support benefits must directly relate to the provision of plan-covered benefits.	Describe how benefits relate to plan-covered benefits, as well as any limitations (e.g., number of counseling/support sessions covered per year, number of hours/days of respite care covered per year and/or episode).

Proposed Benefit Category	Benefit Description	Acceptable Means of Delivery	PBP Description
Home Assessments, Modifications, and Assistive Devices for Home Safety	Coverage of home safety/assistive devices and home assessments and modifications beyond those permitted in chapter 4 of the MMCM. Coverage may include items/services such as rails in settings beyond the enrollee's bathroom.	Home assessments would be performed by trained personnel (e.g., occupational therapists), or by persons with qualifications required by the state, if applicable.	Describe benefit comprehensively, and clearly distinguish safety assessments and devices already covered under chapter 4 of the MMCM from additional benefits qualified SNPs could provide. Describe enrollee criteria for receiving these additional benefits (e.g., enrollee at risk of falls, etc.)
Adult Day Care Services	Services such as recreational/social activities, meals, assistance with ADLs/IADLs, education to support performance of ADLs/IADLs, physical maintenance/rehabilitation activities, and social work services.	Provided by staff whose qualifications and/or supervision meet state licensing requirements.	Describe the criteria imposed for receipt of adult day care services (e.g., prior authorization by a medical practitioner, institutional level of care requirement, etc.)

20.2.6.3 – Benefit Flexibility Approval Process

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

In order for a D-SNP to offer the flexible supplemental benefits outlined above, D-SNPs shall:

1. Submit notification to CMS of their intent to offer flexible supplemental benefits;

2. Receive a CMS determination that the D-SNP is eligible;

3. Submit a bid that incorporates the flexible supplemental benefits the D-SNP intends to offer; and

4. Receive CMS approval of the D-SNP's bid.

In order for a D-SNP to offer the flexible supplemental benefits, CMS must first determine the D-SNP meets CMS's eligibility requirements. Each year, CMS issues guidance in HPMS informing D-SNPs of the deadline to request a CMS review of its contract to determine if the D-SNP may offer flexible supplemental benefits as part of their bid for the respective contract year. D-SNPs are required to submit this notification on plan letterhead to CMS's mailbox located at: https://dmao.lmi.org. This request should also include the following identifying information:

- Contract Number/ID;
- Contract Name;
- Plan Number/ID;
- Plan Type; and
- Contract Year for which the D-SNP intends to offer flexible supplemental benefits.

Once CMS is notified of an existing D-SNP's intent to offer these flexible supplemental benefits, CMS will review the following elements for each requesting D-SNP:

- SMAC;
- Past performance data, inclusive of star ratings and/or HEDIS measures; and
- CMS's MOC approval period.

CMS reviews these elements to render its decision on whether or not the D-SNP meets CMS eligibility requirements. CMS issues a decision on the D-SNP's eligibility through HPMS in advance of the bid submission deadline in order to provide eligible D-SNPs sufficient time to establish any provider contracts that may be necessary in order to offer flexible supplemental benefits.

If CMS deems that a D-SNP is eligible, then the D-SNP may incorporate the flexible supplemental benefits into its bid submission. If CMS deems that a D-SNP is not eligible, then the D-SNP may not incorporate the flexible supplemental benefits into its bid submission.

Eligible D-SNPs that choose to offer flexible supplemental benefits shall include the proposed benefit(s) as a part of their PBPs during bid submission. The plan must attest, at the time of bid submission, that the flexible supplemental benefit(s) described in the PBP does not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid Plan, Medicare Part A or B, or through the

local jurisdiction in which they reside. CMS will review the flexible supplemental benefit(s) submitted with the PBPs and determine whether these benefits comply with the requirements.

20.3 – Institutional SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

20.3.1 – General
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

I-SNPs are SNPs that restrict enrollment to 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 for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility. A complete list of acceptable types of institutions can be found in the Medicare Advantage Enrollment and Disenrollment Guidance at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html.

For information regarding the assessment of an enrollee's level of care (LOC) needs, see section 40.2.3 of this chapter.

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. As with all MA plans, CMS will monitor the plan's marketing/enrollment practices and long-term care facility contracts to confirm that there is no discriminatory impact.

20.3.2 – Institutional Equivalent SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

For an I-SNP to enroll MA eligible individuals living in the community, but requiring an institutional LOC, the following two conditions must be met:

1. A determination of institutional LOC that is 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, I-SNPs must use the same LOC determination methodology used in the respective state or territory in which the I-SNP is authorized to enroll eligible individuals.

2. The I-SNP must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective I-SNP) with the requisite professional knowledge to identify accurately the institutional LOC needs. Importantly, the I-SNP cannot own or control the entity.

20.3.3 – Change of Residence Requirement for I-SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

If an I-SNP enrollee changes residence, the I-SNP must document that it is prepared to implement a CMS-approved MOC at the enrollee's new residence, or in another I-SNP contracted LTC setting that provides an institutional level of care.

20.3.4 – I-SNPs Serving Long-Term Care Facility Residents
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

I-SNPs that serve residents of LTC facilities must own, operate, or have a contractual arrangement with the LTC facility. The LTC facility must adhere to the I-SNP's approved MOC. CMS requires that the contract between the I-SNP and the LTC facility include the following:

1. Facilities in a chain organization must be contracted to adhere to the I-SNP MOC.

   If the I-SNP's contract is with a chain organization, the chain organization and the applicant agree that the facilities listed will adhere to the approved I-SNP MOC.

2. Facilities must provide I-SNP clinical staff access to the I-SNP enrollees.

   The contracted facility must agree to provide I-SNP clinical staff appropriate access to the I-SNP enrollees residing in the facility. The I-SNP clinical staff includes physicians, nurses, nurse practitioners, and care coordinators, in accordance with the I-SNP protocols for operation.

3. The I-SNP must provide protocols in accordance with the approved I-SNP MOC.

   The I-SNP must agree to provide protocols to the facility for serving the I-SNP enrollees in accordance with the approved I-SNP MOC. The I-SNP's contract with the facility must reference these protocols.

4. Delineation of services provided by the I-SNP staff and the LTC facility staff must be specified.

   The I-SNP staff and the facility staff must provide a delineation of the specific services to the I-SNP enrollees, in accordance with the protocols and payment for the services provided by the facility.

5. A training plan for LTC facility staff to understand the MOC must be included.

   A training plan must be in place to ensure that LTC facility staff understands their responsibilities in accordance with the approved I-SNP MOC, protocols, and contract. If the training plan is a separate document, the contract should reference

it.

6. Procedures must be developed and in place for facilities to maintain a list of credentialed I-SNP clinical staff.

   Procedures should ensure cooperation between the I-SNP and the facility in maintaining a list of credentialed I-SNP clinical staff in accordance with the facility's responsibilities under Medicare conditions of participation.

7. A contract year for I-SNP must be specified.

   The contract must include the full CMS contract cycle, which begins on January 1 and ends on December 31. The I-SNP may also contract with additional LTC facilities throughout the CMS contract cycle.

8. Grounds for early termination and a transition plan for I-SNP enrollees must be specified.

   The termination clause must clearly state any grounds for early termination of the contract between the I-SNP and the LTC facility. The contract must include a clear plan for transitioning the enrollee should the I-SNP's contract with the LTC facility terminate.

30 – Application, Approval, and Service Area Expansion Requirements

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

30.1 – General

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Every applicant that proposes to offer a SNP must obtain additional CMS approval as an MA-PD plan. A CMS MA-PD contract that is offering a new SNP, or that is expanding the service area of a CMS-approved SNP, needs to complete only the SNP application portion of the MA application if CMS has already approved the service area for the MA contract. Otherwise, if the MAO is planning to expand its contract service area, it must complete both a SNP application and an MA Service Area Expansion (SAE) application for the approval of the MA service area. Further guidance on SAE procedures is provided in section 30.4 of this chapter.

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. This is generally similar to the format of the MA application. The timeline for submitting the SNP application is the same as the MA application timeline. All SNP applications must be submitted electronically through the Health Plan Management System (HPMS) to CMS by the SNP application due date. The MA application and the SNP application for the current contract year are available at http://www.cms.hhs.gov/MedicareAdvantageApps/. The SNP application is located in

appendix I of the MA application.

30.2 – Model of Care Approval

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

As provided under section 1859(f)(7) of the Act, every SNP must have an NCQA-approved MOC. The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. Please note that detailed information regarding the SNP MOC elements and scoring criteria are located in chapter 5 of the MMCM.

The statute gives the Secretary the authority to establish standards for the MOC approval process. The NCQA MOC approval process scores each of the clinical and non-clinical elements of the MOC. SNPs are approved for one, two, or three year periods.

SNPs that have a failing score (less than 70 percent) for their initial MOC submission will have one cure opportunity to achieve a passing score (greater than 70 percent). Regardless of the score following that cure opportunity (provided the score is at least 70 percent), those SNPs will receive a one-year approval. Table 4 below summarizes the MOC review and cure process.

Table 4: Overview of MOC Review and Cure Processes

Score for Initial MOC Submission (%)	Cure Options	Post 1st Cure	Final Approval Status
85% to 100%	No cure options	N/A	3-year approval
75% to 84%	No cure options	N/A	2-year approval
70% to 74%	No cure options	N/A	1-year approval
69% or below	One cure option	70% or higher	1-year approval
69% or below	One cure option	69% or below	No approval

This policy provides added incentive for SNPs to develop and submit comprehensive and carefully considered MOCs for initial NCQA approval and rewards those SNPs that have demonstrated ability to develop quality MOCs.

30.3 – Existing SNP Model of Care Re-Approval and Application Submissions

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

An MAO must submit a MOC if one of the following scenarios applies:

- The MAO seeks to offer a new SNP;
- The MAO's SNP's MOC approval period ends; or
- CMS deems it necessary to ensure compliance with the applicable regulation(s). Examples include:
  - During an audit, if it appears that the MOC is not meeting CMS standards, then CMS may ask the SNP to correct and resubmit the MOC; or
  - During a regulation change involving the MOC, CMS may ask SNPs to resubmit their MOCs to ensure that they meet the new regulatory requirements.

30.4 – Service Area Expansion

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

An MAO may only operate a SNP in its MA-PD approved service area. An MAO may seek to expand its SNP service area either (1) into its existing MA-PD service area, or (2) into a service area(s) where it does not currently operate. Please see table 5 below for application information pertaining to these two different scenarios.

Table 5: SNP SAE Scenarios

	Complete SNP SAE Application?	Complete MA-PD SAE Application?
1. MAO seeks to expand its SNP service area into its existing MA-PD service area.	Yes	No
2. MAO seeks to expand its SNP service area into a service area(s) where it does not currently operate.	Yes	Yes

The proposed SAE may not exceed the existing or pending service area for the MA contract. Please note that every D-SNP must have a SMAC for each state in which the D-SNP operates, and the CMS-approved service area must match the service area delineated in the SMAC. In addition, beginning for CY 2017, MAOs are not required to submit a new MOC when requesting an SAE for a SNP (see the January 14, 2016, HPMS memo "Changes to Special Needs Plan and Medicare-Medicaid Plan Model of Care

Submissions and Updates in the Health Plan Management System").

40 – Enrollment Requirements
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

40.1 – General
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

As specified in section 1859(f) of the Act, SNPs may only enroll individuals who meet the plan's specific eligibility criteria and enrollment requirements. For example, a D-SNP that is approved to serve only a Full Medicaid population may not enroll an individual who is not qualified as a Full Medicaid individual even though the individual may qualify for a different category of Medicaid. Similarly, an individual who has no Medicaid entitlement may not enroll in a D-SNP of any type. A C-SNP approved to serve a population with diabetes may not enroll individuals who do not have the diabetic condition. However, enrollees who are dual eligible and who qualify for a C-SNP can choose to enroll in either a D-SNP or a C-SNP. An individual who loses eligibility and is disenrolled from a SNP may re-enroll in the same SNP if that individual once again meets the specific eligibility criteria of the SNP. In general, limits on enrollment, whether specific to persons with Medicare or for any individual eligible to enroll in the SNP, are not permissible. MAOs, including those offering SNPs, must accept, without restriction, all eligible individuals whose enrollment elections are received during a valid election period. See 42 CFR 422.60 and section 1851(g)(1) of the Act.

42 CFR 422.52(f) stipulates that a SNP must employ a process approved by CMS to verify the eligibility of each individual enrolling in the SNP. SNPs must include elements on the enrollment request that correspond to the special needs criteria of the particular SNP. Refer to policy regarding enrollment request mechanisms, including special guidance for C-SNPs, in the Medicare Advantage Enrollment and Disenrollment Guidance.

SNPs that choose whether to opt in to the Online Enrollment Center (OEC) are held to the same accountability as other MAOs. MAOs must accept enrollments through the OEC. Additional guidance on enrollment processes is available in the Medicare Advantage Enrollment and Disenrollment Guidance. Refer to section 40.2.1 of this chapter and the Medicare Advantage Enrollment and Disenrollment Guidance for more information about C-SNP eligibility verification processes. The Medicare Advantage Enrollment and Disenrollment Guidance also includes information about special election periods (SEPs) for dual-eligible enrollees or enrollees who lose their dual eligibility.

40.2 – Verification of Eligibility
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

40.2.1 – Verification of Eligibility for C-SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

As required of all SNPs, C-SNPs must verify the applicant's special needs status. Prior to enrollment, the C-SNP must contact the applicant's existing provider to verify that the individual has the qualifying condition(s). Not only does contact with the existing provider permit confirmation of the condition(s), but it also affords the opportunity to initiate the exchange of health information and facilitate the smooth transition of care to the C-SNP.

The C-SNP may use, in its effort to obtain eligibility verification from the existing provider, a fax or other dated document that allows the existing provider to select the enrollee's diagnosed chronic condition(s) from the C-SNP list of qualified conditions. The C-SNP should attempt to obtain eligibility verification information from an enrollee's existing provider using methods other than telephone contact. (Note that ESRD C-SNPs may use a physician-signed CMS Form 2728 ESRD Evidence Report as verification of the chronic condition.)

An MAO may request CMS approval to use a Pre-enrollment Qualification Assessment Tool in its process for verifying an individual's eligibility for C-SNP enrollment. (Details regarding the components of this tool and requirements for its use are provided below.) This CMS-approved tool collects information about the chronic condition(s) targeted by the C-SNP directly from the individual and includes a signature line for a physician or other qualified provider to confirm the individual's eligibility for C-SNP enrollment. MAOs approved to use this tool, but unable to obtain verification of the condition from the provider prior to enrollment, may enroll the individual, but the C-SNP must obtain confirmation of the qualifying chronic condition(s) from the existing provider or a plan provider qualified to confirm the condition no later than the end of the first month of enrollment. The organization must advise the enrollee that he/she will be disenrolled from the plan at the end of the second month if his/her eligibility cannot be verified during the first month of enrollment. In that situation, the C-SNP must notify the enrollee within the first seven calendar days of the second month of enrollment that he/she will be disenrolled at the end of that second month.

CMS will approve the use of a Pre-enrollment Qualification Assessment Tool under the following conditions:

- The Pre-enrollment Qualification Assessment Tool includes a set of clinically appropriate questions relevant to the qualifying chronic condition(s) and covers the applicant's past medical history, current signs and/or symptoms, and current medications to provide reliable evidence that the applicant has the applicable condition(s).

- The MAO maintains a record of the results of the Pre-enrollment Qualification Assessment Tool, which includes the date and time of the assessment if completed during a face-to-face interview with the applicant, or the receipt date, if received by mail.

- The MAO conducts a post-enrollment confirmation of each enrollee's information and eligibility using medical information (medical history, current

signs and/or symptoms, diagnostic testing, and current medications) provided by the enrollee's existing provider or a plan provider.

- The MAO ensures that any payment or compensation associated with enrollments will be forfeited if the qualifying chronic condition(s) cannot be confirmed.

- A C-SNP, using a Pre-enrollment Qualification Assessment Tool, that is unable to obtain confirmation of the chronic condition(s) required for C-SNP eligibility from either the enrollee's existing provider or a plan provider during the first month of enrollment must notify the enrollee within the first seven calendar days of the following month that s/he will be disenrolled at the end of that second month of enrollment.

- All information gathered in the Pre-enrollment Qualification Assessment Tool will be held confidential and in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy provisions.

- The MAO tracks the total number of enrollees and the number and percent by condition whose post enrollment verification matches the pre-enrollment verification. Data and supporting documentation is available upon request by CMS.

MAOs must submit an online request for CMS approval to use a Pre-enrollment Qualification Assessment Tool. To request approval, go to https://dmao.lmi.org/ and enter "Pre-enrollment Qualification Assessment Tool" in the subject line, along with the applicable contract (H) number. Whenever a plan changes or adds conditions to the Pre-enrollment Qualification Assessment Tool, CMS requires a new approval.

40.2.2 – Verification of Eligibility for D-SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

A D-SNP must confirm an individual's Medicare and Medicaid eligibility prior to enrollment into the D- SNP. Acceptable proof of Medicaid eligibility may include, for example: a current Medicaid card; a letter from the state agency that confirms entitlement to Medical Assistance; or verification through a systems query to a state eligibility data system. Additional enrollment guidance is located in the Medicare Advantage Enrollment and Disenrollment Guidance.

40.2.3 – Verification of Eligibility for I-SNPs/Level of Care Assessment for Institutional Equivalent SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

When an individual elects to enroll in an I-SNP before she/he has received at least 90 days of institutional LOC, the I-SNP may use a number of sources of information to show that the individual's condition makes it likely that either the length of stay or the need for

an institutional LOC will be at least 90 days. Examples of sources of information that CMS considers appropriate for this purpose include: a state LOC assessment tool; current Minimum Data Set (MDS) data; or a letter from the nursing facility on the organization's letterhead stating that the nursing facility expects the enrollee to require a stay in excess of 90 days.

Pursuant to section 1859(f)(2) of the Act, individuals living in the community may enroll in an I-SNP only if they have been determined to need an institutional LOC. CMS permits I-SNPs serving individuals living in the community who require an institutional LOC to restrict enrollment to those individuals that reside in, or agree to reside in, a contracted assisted living facility (ALF) or continuing care community, as this may be necessary to ensure uniform delivery of specialized care.

Use of an ALF or continuing care community is optional. If a community-based I-SNP limits enrollment to individuals who reside in a specific ALF or continuing care community, a potential enrollee must agree to reside in the MAO's contracted ALF or continuing care community in order to enroll in the SNP. The SNP must demonstrate the need for the limitation on enrollment, and must describe how community resources will be organized and provided.

MAOs requesting to offer a new, or expand an existing, I-SNP to individuals living in the community and requiring an institutional LOC must submit to CMS information via HPMS that pertains to:

- The state LOC assessment tool; and
- The entity performing the LOC assessments.

An entity unrelated to the MAO must perform the assessments. This independent entity may not be an employee of the MAO or its parent organization, and must be an independent contractor or grantee. In addition, the independent entity may not receive any kind of bonus or differential payment for qualifying members for the SNP.

MAOs must submit this required information as a part of their SNP application. Applications for this type of I-SNP are reviewed on a case-by-case basis for approval during the annual MA application cycle. Refer to section 30 of this chapter for further information regarding the SNP application submission.

40.3 – Waiver to Enroll Individuals with ESRD

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Pursuant to section 1851(a)(3)(B) of the Act, MAOs are not permitted to enroll individuals with ESRD. However, a SNP may enroll individuals with ESRD if it has obtained a waiver from CMS to be open for enrollment to individuals with ESRD under 42 CFR 422.52(c). MAOs should request this waiver as part of the SNP application. The ESRD waiver is available to all types of SNPs. CMS's decision to grant an ESRD waiver

is conditional upon the SNP arranging access to services specifically targeted to individuals living with ESRD (e.g., nephrologists, hemodialysis centers, and renal transplant centers).

SNP applicants requesting an ESRD waiver must complete an upload document as part of the SNP application. This document must include:

- A description of how the applicant intends to monitor and serve the unique needs of the ESRD enrollees, including their care coordination.

- A list of any additional service(s) provided to enrollees with ESRD, including a description of how/why these services are relevant to ESRD enrollees. Additional benefits may include, but are not limited to:

    - Transportation;
    - Support groups (e.g., enrollee, family, caregiver); and
    - Self-care education (e.g., nutrition, wound care).

- A description of the interdisciplinary care team's role in the assessment and delivery of services needed by enrollees with ESRD.

- A list of the contracted nephrologist(s) that meets the current CMS-required health services delivery (HSD) access criteria.

- A list of the contracted dialysis facility(ies) that meets the current CMS-required HSD access criteria.

- A description of the dialysis options available to enrollees (e.g., home dialysis, nocturnal dialysis).

- A list of the contracted kidney transplant facility(ies).

- A description of enrollee access to contracted kidney transplant facility(ies), including the average distance enrollees in each county served by the SNP must travel to reach a contracted kidney transplant facility.

SNPs that did not initially elect to enroll ESRD individuals at the time of application must submit a new SNP application if they wish to begin enrolling individuals with ESRD. Refer to section 30 of this chapter for further guidance on the SNP application process. Once CMS approves the ESRD waiver, the SNP must allow all eligible ESRD individuals to enroll, in accordance with the Medicare Advantage Enrollment and Disenrollment Guidance.

40.4 – Continued Eligibility When an Enrollee Loses Special Needs Status

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

A SNP enrollee may become ineligible for the plan following his/her enrollment due to the loss of his/her special needs status. Please refer to the Medicare Advantage Enrollment and Disenrollment Guidance for information on deemed continued eligibility, the length of the grace period, the implications of not regaining eligibility, the potential for involuntary disenrollment, and related enrollment/disenrollment policy issues.

During the period of deemed continued eligibility for a D-SNP specifically, the D-SNP must continue to provide all MA plan-covered Medicare benefits. During this period, the D-SNP is not responsible for continued coverage of Medicaid benefits that are included under the applicable Medicaid State Plan, nor is the D-SNP responsible for Medicare premiums or cost sharing for which the state would be liable had the enrollee not lost his/her Medicaid eligibility. However, cost sharing amounts for Medicare basic and supplemental benefits do not change during this period.

During the period of deemed continued eligibility, MAOs are responsible for knowing:

- The benefits covered for the enrollee;
- The state requirements; and
- The enrollee notification requirements.

40.5 – Special Election Period for Enrollees Losing Special Needs Status to Disenroll from SNP

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

CMS provides a SEP for individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the required special needs status for enrollment. SNPs must send the appropriate notice to the enrollee explaining the disenrollment. Refer to the Medicare Advantage Enrollment and Disenrollment Guidance for additional guidance on SEPs for these individuals.

40.6 – Open Enrollment Period for Institutionalized Individuals

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

An open enrollment period for institutionalized individuals (OEPI) is available for individuals who meet the definition of an "institutionalized individual" to enroll in or disenroll from an I-SNP. Refer to the Medicare Advantage Enrollment and Disenrollment Guidance for further information about the OEPI.

50 – Renewal Options and Crosswalks

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

50.1 – General

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

The guidance in this section specifically applies to SNP renewal options and crosswalks. Table 6 below provides an overview of the SNP crosswalk policy. For general crosswalk guidance, please refer to the Bid Submission User Manual, located under the Plan Bids tab in HPMS. For crosswalk exception guidance, please refer to CMS's annual spring HPMS memo, "Process for Requesting an HPMS Crosswalk Exception."

50.2 – D-SNP Non-Renewals

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Note that all MAOs that offer D-SNPs must have contracts with State Medicaid Agencies in the states in which they operate. In the event that an MAO is not able to secure such a contract (or subcontract) for one or more of its D-SNPs, the MAO must terminate those D-SNPs in accordance with CMS's non-renewal instructions outlined in chapter 11 of the MMCM. Enrollees in those plans will be disenrolled from their D-SNP and may elect to receive services under original Medicare or another MA plan into which they wish to enroll. Enrollees who are dual-eligible have an ongoing SEP and—in the event of a D-SNP non-renewal—will be disenrolled to original Medicare and automatically enrolled in a benchmark stand-alone PDP.

50.3 – SNP Crosswalks

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

MAOs may not crosswalk enrollees from one SNP type to a different SNP type. Please refer to chapter 11 of the MMCM for the standard crosswalk rules applicable to all MA plans, which include all SNPS. The table below outlines the crosswalk scenarios for D-SNPs, C-SNPs, and I-SNPs.

Table 6: SNP Crosswalk Scenarios

D-SNP Crosswalks					
Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Enrollee Notifications
(1) Renewing D-SNP that transitions eligible enrollees into another D-SNP (Please note: This scenario requires a crosswalk exception. MAOs seeking this crosswalk must obtain prior approval from CMS by submitting a crosswalk exception request.)	An MAO renews a D-SNP PBP for the upcoming CY and also has another available D-SNP PBP for the upcoming CY. These two D-SNP PBPs are offered to different populations.	Crosswalk Exception Request: MAOs cannot complete the transition of current eligible enrollees to the other D-SNP PBP via the HPMS Plan Crosswalk. MAOs must submit a Crosswalk Exception Request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. HPMS Plan Crosswalk Definition: An MAO is offering more than one D-SNP PBP and wishes to	The renewal D-SNP PBP ID must remain the same so that the HPMS Plan Crosswalk will indicate that enrollees remain in the same D-SNP PBP. The MAO must submit enrollment transactions to transition current eligible enrollees into the other D-SNP PBP. Enrollees not transitioned by the submission of enrollment	No enrollment request is required for current enrollees to remain enrolled in the renewing D-SNP PBP in the upcoming CY. New enrollees must complete an enrollment request.	Enrollees transitioned into the other D-SNP PBPreceive a standard ANOC.

		move enrollees between them and keep the D-SNP PBPs.	transactions will remain enrolled in the renewing D-SNP PBP.		
(2) Renewing D-SNP in a multi-state service area with a SAR to accommodate state contracting efforts in portions of that service area (Please note: This scenario requires a crosswalk exception. MAOs seeking this crosswalk must obtain prior approval from CMS by submitting a crosswalk exception request.)	An MAO reduces the service area of a previous CY D-SNP PBP to accommodate state contracting efforts in a multi-state service area.	Crosswalk Exception Request: MAOs cannot complete the transition of current eligible enrollees to one or more new or renewing upcoming CY D-SNP PBPs via the HPMS Plan Crosswalk. MAOs must submit a Crosswalk Exception Request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. HPMS Plan Crosswalk Definition: An upcoming	The renewal D-SNP PBP ID must remain the same so that the HPMS Plan Crosswalk will indicate that enrollees remain in the same D-SNP PBP. The MAO must submit enrollment transactions to transition current eligible enrollees in the reduced portion of the service area of the previous CY D-SNP PBP into the new or	No enrollment request is required for current enrollees in the remaining portion of the service area to remain enrolled in the renewing D-SNP PBP in the upcoming CY. New enrollees must complete enrollment request.	Current enrollees in the renewal portion of the service area receive a standard ANOC. Current enrollees in the reduced portion of the service area who are transitioned to a new or renewing D- SNP PBP receive a standard ANOC.

		CY D-SNP PBP that links to a previous CY D-SNP PBP and only retains a portion of its plan service area. The upcoming CY D-SNP PBP must retain the same D-SNP PBP ID as the previous CY D-SNP PBP. In addition, a new D-SNP PBP is added for the upcoming CY that is not linked to a previous CY. HPMS Plan Crosswalk Designation: Renewal Plan with a SAR AND/OR New Plan AND/OR Renewal Plan	renewing upcoming CY D-SNP PBP(s). Enrollees not transitioned by the submission of enrollment transactions will remain enrolled in the renewing D-SNP PBP.		
C-SNP Crosswalks					
Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment	Enrollment Procedures	Enrollee Notification

			Activities		s
(1) Renewing C-SNP with one chronic condition that transitions eligible enrollees into another C-SNP with a CMS-approved grouping which contains that same chronic condition	An MAO combines one or more whole MA PBPs of the same type offered in the previous CY into a single renewal PBP so that all current eligible enrollees in the combined PBP are offered the same benefits in the upcoming CY. The MAO must designate which of the renewal PBP IDs will be retained in the CY after consolidation. CMS will not allow for consolidations across contracts (with limited exceptions for some renewal options, as described elsewhere in chapter 4). Only whole PBPs may be consolidated;	HPMS Plan Crosswalk Definition: One or more previous CY plans that consolidate into one plan for the upcoming CY. The plan ID for the upcoming CY must be the same as one of the consolidating previous CY plan IDs. HPMS Plan Crosswalk Designation: Consolidated Renewal Plan	The renewal C-SNP PBP ID must remain the same so that CMS may consolidate enrollees into the renewal C-SNP PBP ID in HPMS. The MAO does not submit enrollment transactions for current eligible enrollees. The MAO may have to submit 4Rx data for enrollees whose PBP ID changed.	No enrollment request is required for current eligible enrollees to remain enrolled in the renewing C-SNP PBP in the upcoming CY. New enrollees must complete an enrollment request.	Current enrollees receive a standard ANOC.
(2) Renewing C-SNP with a CMS-approved grouping that transitions eligible enrollees into another C-SNP with one of the chronic conditions from that grouping (Please note: This scenario requires a crosswalk exception.				Submit MARx disenrollment transactions to disenroll ineligible enrollees.	Current enrollees receive a standard ANOC.

MAOs seeking this crosswalk must obtain prior approval from CMS by submitting a crosswalk exception request.)	a previous CY PBP may not be split among different PBPs in the upcoming CY. Note: If an MAO reduces a service area when consolidating PBPs, it must follow the rules for a plan renewal with SAR described elsewhere in chapter 4.				
(3) Non-renewing C-SNP in a CMS-approved grouping that transitions eligible enrollees to a different CMS-approved grouping C-SNP if the new grouping contains at least one condition that the prior plan contained				Submit MARx disenrollment transactions to disenroll ineligible enrollees.	Current enrollees receive a standard ANOC.
I-SNP Crosswalks					
Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Enrollee Notifications
(1) Renewing Institutional SNP that transitions enrollees to an	An MAO combines one or more whole MA PBPs of the same type offered in the	HPMS Plan Crosswalk Definition: One or more previous CY plans that consolidate	The renewal I-SNP PBP ID must remain the same so that CMS	No enrollment request is required for current eligible enrollees to	Current enrollees receive a standard ANOC.

Institutional/ Institutional Equivalent SNP	previous CY into a single renewal PBP so that all current eligible enrollees in the combined PBP are offered the same benefits in the upcoming CY. The MAO must designate which of the renewal PBP IDs will be retained in the CY after consolidation. CMS will not allow for consolidations across contracts (with limited exceptions for some renewal options, as described elsewhere in chapter 4). Only whole PBPs may be consolidated; a previous CY PBP may not be split among different PBPs in the upcoming CY. Note: If	into one plan for the upcoming CY. The plan ID for the upcoming CY must be the same as one of the consolidating previous CY plan IDs. HPMS Plan Crosswalk Designation: Consolidated Renewal Plan	may consolidate enrollees into the renewal I-SNP PBP ID in HPMS. The MAO does not submit enrollment transactions for current eligible enrollees. The MAO may have to submit 4Rx data for enrollees whose PBP ID changed.	remain enrolled in the renewing I-SNP PBP in the upcoming CY. New enrollees must complete an enrollment request.	
(2) Renewing Institutional Equivalent SNP that transitions enrollees to an Institutional/ Institutional Equivalent SNP					Current enrollees receive a standard ANOC.
(3) Renewing Institutional/ Institutional Equivalent SNP that transitions eligible enrollees to an Institutional SNP					Current enrollees receive a standard ANOC.
(4) Renewing Institutional/ Institutional Equivalent SNP that transitions eligible enrollees to an Institutional Equivalent SNP				Submit MARx disenrollment transactions to disenroll ineligible enrollees.	Current enrollees receive a standard ANOC.
(5) Non-renewing Institutional/ Institutional Equivalent					Current enrollees receive a standard ANOC.

SNP that transitions eligible enrollees to another Institutional/ Institutional Equivalent SNP	an MAO reduces a service area when consolidating PBPs, it must follow the rules for a plan renewal with SAR described elsewhere in chapter 4.				

60 – Marketing
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

As with any MA plan, SNPs must market to all individuals eligible to enroll. For example, if a SNP is offered for institutionalized enrollees at select LTC facilities, the SNP must market to all Medicare Part A and/or Part B enrollees residing in those facilities. D-SNPs may wish to work with their respective states to identify an acceptable method of marketing towards dual-eligible enrollees. Refer to the Medicare Marketing Guidelines for further information on marketing requirements for SNPs.

70 – Covered Benefits
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

70.1 – Part D Coverage Requirement
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

All SNPs must offer Part D prescription drug coverage, regardless of whether or not the MAO offers a CCP with Part D benefits in the same service area. Refer to 42 CFR 422.2 and chapter 4 of the MMCM for more information about this requirement.

70.2 – SNP-Specific Plan Benefit Packages
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

CMS expects MAOs offering SNPs to have a well-developed MOC, to structure their health care service delivery system to support this model, and to design their PBP to address the specialized needs of the targeted enrollees. All SNPs should have specially designed PBPs that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all CCPs. These SNP-specific PBPs should include, but not be limited to:

- Supplemental health benefits specific to the needs of the unique SNP population;

- Specialized provider networks (e.g., physicians, home health, hospitals, etc.) specific to the unique SNP population; and

- Appropriate enrollee cost sharing structured around the unique SNP population's health conditions and co-morbidities for all Medicare-covered and supplemental benefits.

The following are examples of SNP benefits that exceed basic Medicare Parts A and B benefits:

- No or lower cost sharing;

- Longer benefit coverage periods for inpatient services;

- Longer benefit coverage periods for specialty medical services;

- Parity (equity) 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.

All social-support services must be approved supplemental benefits consistent with the guidance in chapter 4 of the MMCM.

70.3 – Meaningful Difference in Plan Benefits
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

To determine whether SNPs satisfy the meaningful difference requirement outlined in chapter 4 of the MMCM, SNPs are evaluated by groups or subgroups, as appropriate, of SNP types, as follows:

- C-SNPs: Separated by the chronic disease served.

- I-SNPs: Separated into the categories of either Institutional (Facility), Institutional Equivalent (Living in the Community), or a combination of Institutional and Institutional Equivalent.

- D-SNPs: Excluded from the meaningful difference evaluation.

For more information on CMS's meaningful difference requirements for SNPs, please

refer to the annual "Announcement," located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

80 – Quality Improvement

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

The quality improvement requirements applied to non-SNP MA plans are also applied to SNPs. Pursuant to 42 CFR 422.152(c)-(g), each SNP must conduct both a Chronic Care Improvement Program (CCIP) and a Quality Improvement Project (QIP) targeting the special needs population that it serves. Refer to chapter 5 of the MMCM for further guidance on SNP quality improvement and reporting requirements.