Department of Health & Human Services
Centers for Medicare & Medicaid Services
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CENTER FOR DRUG AND HEALTH PLAN CHOICE

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TO: Medicare Advantage Organizations offering Special Needs Plans

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SUBJECT: CMS Expectations of Special Needs Plans for 2010

The purpose of this memorandum is to provide clarification and updates important to the administration and operations of Medicare Advantage Special Needs Plans (SNP). Included with this communication are items that should be considered as you plan for the 2010 and 2011 contract years.

Medicaid Contracts for Dual Eligible Special Needs Plans

The Medicare Improvements for Providers and Patients Act of 2008 (MIPPA) required that Medicare Advantage Organizations (MAO) contract with their respective state Medicaid Agencies for all new or expanding dual eligible special needs plans (DE SNP). Existing DE SNPs that were not required to have a contract with Medicaid State Agencies were "grandfathered" by MIPPA for 2010 only. Effective January 1, 2011, ***all*** dual eligible SNPs are required to have a ratified contract for 2011. Additionally, the contract element regarding the MAO/SNP cost sharing protection obligation is to more specifically include beneficiary protections regarding cost sharing (see #4 below) for non-Part D pharmacy items. The eight elements required in the 2010 contracts (as outlined in §422.107) are as follows:

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

The deadline for submitting state Medicaid contracts for 2011 is now September 1, 2010. This will allow the necessary time needed to receive, review, and communicate

status to plans before the MA contracting process begins and final bids are confirmed. Decisions will be made in time for plans to begin marketing.

Pharmacy Cost Sharing

It was brought to CMS' attention that in some cases pharmacies are not receiving the full allowable payment for Part B medications. Although CMS regulations at 42 CFR 422.504(g)(1)(iii) are intended to protect dual eligible beneficiaries from cost-sharing that is the responsibility of the state, some pharmacies are experiencing problems with recouping the cost share portion for Part B benefits (e.g., cancer treatment, non-Part D pharmacy items) supplied to dual eligible beneficiaries. CMS is seeking suggestions for the ways in which MAOs may partner and/or contract with state Medicaid agencies in order to ensure that beneficiaries are protected and that pharmacies are appropriately reimbursed. Suggestions should be sent to Lavern Baty (lavern.baty@cms.hhs.gov) by January 29, 2010.

SNP Plan Benefit Package Analysis

An MAO choosing to offer a SNP must demonstrate a commitment to providing improved access to medical, social, psychological, and function-restoring services rendered by providers with specialized expertise pertinent to the target population. Such a commitment is evidenced by a model of care that is based on a service delivery system designed for the target population.

CMS recently compared 2010 SNP-specific plan benefit packages (PBPs) to other MA plan PBPs available in the same service area, and found that many MAOs designed the same benefit package for both SNPs and other MA products offered in the same service area. The majority of MAOs offering both SNPs and other MA products in the same service area had only reduced cost sharing as the SNP-specific benefit. In fact, in several cases, the traditional MA PBP was more robust than the MAO's SNP benefit package. CMS expects that MAOs offering SNPs to begin with a well-developed model of care and structure their service delivery system to support this model, and design their benefit package to address the specialized needs of the targeted beneficiaries. In addition, SNP-specific PBPs should incorporate some or all of the following examples of benefits that exceed the basic required Medicare A and B benefits offered by other MA products available in the same service area:

- No or lower beneficiary 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, etc.)
- End-of-life services (e.g., assistance with developing advance directives, medication management, home-based care, etc)
- Social services (connection to community resources for economic assistance, etc.)
- Transportation services
- Wellness programs to prevent the progression of chronic conditions, etc.

In 2010, CMS will continue to analyze the SNP PBPs to identify best practices and recommendations for designing plan benefit packages that demonstrate recognition of the specialized needs of target populations. If we believe that benefits could be more robust, we may provide targeted guidance to MAOs before approving SNP PBPs. CMS will offer more targeted recommendations and direction for the development of PBPs in 2011.

SNP Quality Reporting

As an MAO, all SNPs are required to have an overall quality improvement program. Effective July 2008, MIPPA expanded the quality improvement requirements for SNPs to collect, analyze, and report data that measures health outcomes and quality indices of care management, as well as the effectiveness of their models of care.

CMS is reframing the quality improvement program as a continuous performance improvement program for all MAO products that includes collection and analysis of data that: 1) assists the public in selecting plans that meet acceptable performance levels; 2) assists CMS in monitoring plan performance; and 3) sets minimum requirements for MA plans to assess their own performance through a robust internal performance improvement program. CMS encourages MAOs to develop and implement expansive and effective performance improvement plans that meet the needs of Medicare beneficiaries and support efficient and successful operations.

2011 SNP Proposal Section of the MA Application

During the 2010 MA application cycle, CMS permitted MAOs offering chronic condition SNPs (C-SNPs) to select one of 15 CMS-approved chronic conditions as the exclusive eligibility condition. Once we approved the C-SNP for the target condition, we allowed MAOs to design SNP plan benefit packages that grouped chronic conditions in one of two ways:

1) One of five CMS-approved groups of two or three conditions that were commonly co-morbid and clinically related in which the eligible beneficiary has one of the grouped conditions; and/or

2) An MAO-customized group of chronic conditions selected from the list of 15 CMS-approved chronic conditions in which the eligible beneficiary has all of the grouped conditions.

For the 2011 MA application cycle, CMS has revised the automated 2011 SNP proposal section of the MA application to expand options at the point of application. When completing the SNP proposal application, MAOs can choose to offer a C-SNP targeting:

1) A single CMS-approved chronic condition;

2) A CMS-approved group of chronic conditions; or

3) An MAO-customized grouping of chronic conditions selected from the 15 CMS-approved SNP-specific chronic conditions.

Denying SNPs Based on Deficient SNP Proposal Element.

MAOs and Part D sponsors applying to contract with CMS in 2011 or existing MAOs applying for service area expansions must also submit a 2011 SNP proposal if they wish to offer a SNP targeting special needs individuals. CMS will independently review each of these three applications – the MA application, Part D application, and SNP proposal - and will notify MAOs in separate correspondence what deficiencies were found in the MA application, Part D application, and SNP proposal. MAOs must then cure any deficiencies in each of the original automated applications prior to CMS approval. Even if an applicant does not cure deficiencies in its SNP proposal, it could still be approved as an MA organization and/or Part D plan sponsor based on curing any deficiencies in those applications.

HPMS Repository for Model of Care and Quality Improvement Program Data

In June 2009, CMS required all MAOs to submit information on their models of care and overall quality improvement programs. The purpose of collecting this information was to develop a database that would serve as a perpetual repository of data that MAOs could continue to update as they evaluate and revise their healthcare management systems. CMS is deferring the development of this program database to a later date and will keep the industry informed of our progress. In the interim, we are collaborating with a contractor to analyze the data submitted by MAOs in June and report on trends related to SNP models of care and quality improvement programs. We intend to use this to inform best practices for SNPs that target different special needs populations.

Non-Special Needs Enrollees in MA Special Needs Plans (SNPs) beyond January 1, 2010

Section 50.2.5 of Chapter 2 of the Medicare Managed Care Manual requires SNPs to identify and notify individuals by March 31, 2010 who, as of January 1, 2010, did not meet all applicable eligibility criteria. CMS is revising this requirement to request that MAOs identify these individuals and report the total number of these individuals to their CMS account manager by June 30, 2010. CMS will provide additional guidance regarding the notification requirements in the future.