

Medicare Managed Care Manual

Chapter 16b: Special Needs Plans

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10 - Introduction

10.1 - General

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, into distinct subchapters. The contents of this chapter are generally limited to the statutory framework set forth in Sections 1851-1859 of the Social Security Act (the Act), and are governed by regulations set forth in Chapter 42 of the Code of Federal Regulations, Part 422, (42 CFR 422.1 et seq.). This chapter also references other chapters of the Medicare Managed Care Manual that pertain to enrollment, benefits, marketing, and payment guidance related to special needs individuals.

To assist MA organizations 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 (C-SNP), dual eligible (D-SNP), and institutional (I-SNP), as described in Section 20 of this chapter.

Table 1: Chapter Sections Applicable to Certain SNP Types

Type of Special Needs Plan	Applicable Sections
Chronic	20.1; 30.3; 40.7; 50.2.3
Dual eligible	20.2; 30.2; 40.4.2; 40.4.3; 40.4.4; 40.4.5; 40.5; 50.2.1; 60.2; 70.2; 80.4
Institutional	20.3; 40.4.1; 40.6; 50.2.2; 50.7; 70.3; 80.4.3

10.2 - Statutory and Regulatory History

The Medicare Modernization Act of 2003 (MMA) established an MA CCP that was specifically designed to provide targeted care to individuals with unique special needs. In the MMA, Congress identified "special needs individuals" as: 1) institutionalized beneficiaries; 2) dual eligibles; and/or, 3) individuals with severe or disabling chronic conditions, as specified by CMS. MA CCPs that are established to provide services to these special needs individuals are called "Specialized MA plans for Special Needs Individuals," or SNPs. 42 CFR Section 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 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 the 2009 contract year.

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 expansions until calendar year (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 (D-SNPs), (I-SNPs), and (C-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 Sections 422.501- 422.504.

Effective immediately upon its enactment in 2011, the Patient Protection and Affordable Care Act (the ACA) extended the SNP program through December 31, 2013, and mandated further SNP program changes. Section 3205(e) of the ACA amends Section 1859(f) of the Act to:

- Require all SNPs to submit Models of Care (MOCs) that comply with an approval process based on CMS standards; these MOCs must be reviewed and approved by the National Committee for Quality Assurance (NCQA) beginning January 1, 2012 (see Section 40.2 of this chapter);
- Permit existing D-SNPs to continue operating through 2012 without a State Medicaid contract in their current service areas (See Section 40.5.1 of this chapter);
- Authorize CMS to pay a frailty adjustor payment to fully integrated dual eligible SNPs (FIDE SNPs) (See Section 30.2 of this chapter);
- Establish new cost sharing requirements for SNP (See Section 80.4.2 of this chapter); and
- Require CMS to implement new quality-based payment procedures for all MA plans by 2012.

Most recently, Section 607 of the American Taxpayer Relief Act of 2012 (ATRA) extended the SNP program through December 31, 2014.

20 - Description of SNP Types

SNPs may be any type of MA CCP, including either a local or regional preferred provider organization (PPO) plan, a health maintenance organization (HMO), or HMO Point of Service (HMO POS), which are MA CCP types described in Chapter 1 of the Medicare Managed Care Manual. This section describes the 3 types of SNPs (i.e., chronic, dual, and institutional) in further detail.

20.1 - Chronic Condition SNPs (C-SNPs)

20.1.1 - General

Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions defined in 42 CFR Section 422.2.

Approximately two-thirds of Medicare beneficiaries have multiple chronic conditions requiring coordination of care among primary providers, medical and mental health specialists, inpatient and outpatient facilities, and extensive ancillary services related to diagnostic testing and therapeutic management. C-SNPs are designed to narrowly target enrollment to Medicare beneficiaries who have severe or disabling chronic conditions.

20.1.2 - List of Chronic Conditions

Section 1859(b)(6)(B)(iii) of the Act and 42 CFR Section 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.” As required under Section 1859(b)(6)(B)(iii) of the Act, 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 fifteen SNP-specific chronic conditions listed below:

- (1) Chronic alcohol and other drug dependence;
- (2) Autoimmune disorders limited to:
 - Polyarteritis nodosa;
 - Polymyalgia rheumatica;
 - Polymyositis;
 - Rheumatoid arthritis;
 - Systemic lupus erythematosus.
- (3) Cancer, excluding pre-cancer conditions or in-situ status;
- (4) Cardiovascular disorders limited to:
 - Cardiac arrhythmias;
 - Coronary artery disease;
 - Peripheral vascular disease;
 - Chronic venous thromboembolic disorder.

(5) Chronic heart failure;

(6) Dementia;

(7) Diabetes mellitus;

(8) End-stage liver disease;

(9) End-stage renal disease requiring dialysis;

(10) Severe hematologic disorders limited to:

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

(11) HIV/AIDS;

(12) Chronic lung disorders limited to:

- Asthma;
- Chronic bronchitis;
- Emphysema;
- Pulmonary fibrosis;
- Pulmonary hypertension.

(13) Chronic and disabling mental health conditions limited to:

- Bipolar disorders;
- Major depressive disorders;
- Paranoid disorder;
- Schizophrenia;
- Schizoaffective disorder.

(14) Neurologic disorders limited to:

- Amyotrophic lateral sclerosis (ALS);
- Epilepsy;
- Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia);
- Huntington's disease;
- Multiple sclerosis;
- Parkinson's disease;
- Polyneuropathy;

- Spinal stenosis;
- Stroke-related neurologic deficit.

(15) Stroke

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

20.2 - Dual Eligible SNPs (D-SNPs)

20.2.1 - General

D-SNPs enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid). These Medicaid eligibility categories encompass all categories of Medicaid eligibility including – Qualified Medicare Beneficiary without other Medicaid (QMB only); QMB+; Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only); SLMB+; Qualifying Individual (QI); other full benefit dual eligible (FBDE); 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 we listed here.

Definitions of these categories are listed below.

(Note: The “+” refers to eligibility for the full State Medicaid benefit):

- **Qualified Medicare Beneficiary without other Medicaid (QMB only):** An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- **Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits (QMB+):** An individual entitled to Medicare Part A, with income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full

Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level^{1 2}. Medicaid does not pay towards the out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

- **Specified Low-income Medicare Beneficiary without other Medicaid (SLMB only):** An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- **Specified Low-income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+):** An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits. These individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- **Qualifying Individual (QI):** An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- **Qualified Disabled and Working Individual (QDWI):** An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

¹ The "medically needy" program allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

² When "spending down," an individual reaches Medicaid eligibility by incurring medical and/or remedial care expenses to offset his/her excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan.

- **Other Full Benefit Dual Eligible (FBDE):** An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Table 2 below summarizes Medicaid coverage of Medicare benefits by category of dual eligibility. Although Medicaid does not pay Part D premiums or Part D cost sharing for dual eligible individuals, QMBs, SLMBs, and QIs are automatically enrolled in Medicare's low income subsidy (LIS) program, which provides assistance with Part D prescription drug costs. More information about the LIS program is available at <http://www.cms.gov/limitedincomeandresources/>.

Table 2: Medicaid Benefits by Medicaid Eligibility Category

Dual Eligible Category	Full Medicaid	Medicaid coverage of Medicare Premiums and Cost sharing				Medicaid coverage of Medicare Part C Premiums and Cost sharing		
		Part A Premium	Part B Premium	Part D Premium ³	OOP Cost sharing	Premium		OOP Cost sharing
						Part A, Part B & Mandatory Supplemental	Optional Supplemental	Required
QMB	No	Yes	Yes	No	Yes	Optional	Not Permitted	Required
QMB+	Yes	Yes	Yes	No	Yes	Optional	Optional	Required
SLMB	No	No	Yes	No	No	Not Permitted	Not Permitted	Not Permitted
SLMB +	Yes	No	Yes	No	No	Not Permitted	Optional	Conditional
QI	No	No	Yes	No	No	Not Permitted	Not Permitted	Not Permitted
QDWI	No	Yes	No	No	No	Not Permitted	Not Permitted	Not Permitted
FBDE	Yes	No	No	No	No	Not Permitted	Optional	Conditional

CMS has specified the following five D-SNP type categories:

- ***All-Dual D-SNPs;***
- ***Full-Benefit D-SNPs;***

³ QMBs, SLMBs, and QIs are automatically enrolled in the low-income subsidy program and are, therefore, not subject to the Medicare Part D premium.

- *Medicare Zero Cost-sharing;*
- *Dual Eligible Subset; and,*
- *Dual Eligible Subset - Medicare Zero Cost-sharing.*

We describe each of these D-SNP types in detail in the following subsections. Table 3 below lists the five CMS approved enrollment categories for D-SNPs and summarizes the Medicaid eligibility category that each of these D-SNP types may enroll. Note that a dual eligible subset D-SNP may choose to enroll any category or combination of Medicaid eligibility categories, as long as CMS approves the subset and the D-SNP's enrollment limitations parallel the structure and care delivery patterns of the State Medicaid program in the State in which the D-SNP operates.

Table 3: Medicaid Eligibility Categories Permitted to Enroll in D-SNP Types

D-SNP Type	Category of Medicaid Eligibility						
	QMB	QMB+	SLMB	SLMB+	QI	QDWI	FBDE
<i>All-Dual</i>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<i>Full-Benefit</i>	No	Yes	No	Yes	No	No	Yes
<i>Medicare Zero Cost sharing</i>	Yes	Yes	No	No	No	No	No
<i>Dual Eligible Subset</i>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<i>Dual Eligible Subset Medicare Zero Cost-sharing</i>	Yes	Yes	Yes	Yes	Yes	Yes	Yes

20.2.2 - All-Dual D-SNPs

An all-dual D-SNP enrolls beneficiaries who are eligible for Medicare Advantage and who are entitled to medical assistance under a State/Territorial plan under Title XIX of the Act. An all-dual D-SNP must enroll all categories of dual eligible individuals, including those with comprehensive Medicaid benefits as well as those with more limited cost sharing.

20.2.3 - Full-Benefit D-SNPs

A full-benefit D-SNP enrolls individuals who are eligible for:

- (1) Medical assistance for full Medicaid benefits for the month under any eligibility category covered under the Medicaid State Plan or comprehensive benefits under a demonstration under Section 1115 of the Act; or,
- (2) Medical assistance under Section 1902(a)(10)(C) of the Act (Medically Needy) or Section 1902(f) of the Act (States that use more restrictive eligibility criteria than are

used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

Sections 1902(a), 1902(f), 1902(p), 1905, and 1935(c)(6) of the Act describe categories of individuals who are entitled to full Medicaid benefits. This includes QMB+ individuals, SLMB+ individuals, and other FBDEs. The “+” refers to eligibility for the full State Medicaid benefit.

20.2.4 - Medicare Zero Cost Sharing D-SNPs

This type of D-SNP limits enrollment to QMBs only and QMBs with comprehensive Medicaid benefits (QMB+), the two categories of dual eligible beneficiaries who are not financially responsible for cost sharing for Medicare Parts A or B. Because QMB-only individuals are not entitled to full Medicaid benefits, there may be Medicaid cost sharing required.

20.2.5 - Dual Eligible Subset D-SNPs

MA organizations that offer D-SNPs may exclude specific groups of dual eligibles based on the MA organization’s coordination efforts with State Medicaid agencies. CMS reviews and approves requests for coverage of dual eligible subsets on a case-by-case basis. To the extent that a State Medicaid Agency excludes specific groups of dual eligibles from their Medicaid contracts or agreements; those same groups may also be excluded from enrollment in the SNP, as long as the enrollment limitations parallel the structure and care delivery patterns of the State Medicaid program. ***Dual Eligible Subset D-SNPs can be a Dual Eligible Subset that includes a cost sharing (Dual Eligible Subset) or not (Dual Eligible Subset Medicare Zero Cost-sharing). Examples of these types of subsets are listed below (refer to Tables 2 and 3 in Section 20.2.1):***

- ***The State Medicaid Agency stipulates in its State Medicaid Agency contract that the D-SNP will enroll only full benefit disabled dual eligible beneficiaries aged 18 – 64. (Dual Eligible Subset -- where SLMB+beneficiaries may have an out of pocket cost sharing)***
- ***The State Medicaid Agency stipulates in its State Medicaid Agency contract that the D-SNP will enroll only QMB and QMB+ disabled dual eligible beneficiaries aged 18-64 and provide Medicaid coverage for all premiums and cost sharing for QMB and QMB+ duals. (Dual Eligible Subset, Medicare Zero Cost-sharing)***
- ***The State Medicaid Agency stipulates in its State Medicaid Agency contract that the D-SNP will enroll only full benefit dual eligible beneficiaries aged 65+ and provide coverage for premiums and cost sharing for all beneficiaries enrolled in the D-SNP. (Dual Eligible Subset, Medicare Zero-Cost sharing)***

20.3 - Institutional SNPs (I-SNPs)

20.3.1 - General

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 the mentally retarded (ICF/MR), or an inpatient psychiatric facility. A complete list of acceptable types of institutions can be found in Chapter 2 of the Medicare Managed Care Manual.

For information regarding the assessment of a beneficiary's level of care (LOC) needs, see section 50.2.2 of this chapter.

20.3.2 - Institutional Equivalent SNPs

A SNP that enrolls MA eligible individuals living in the community, but requiring an institutional level of care, must meet both of the following eligibility requirements:

- (1) A determination of institutional level of care (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, SNPs must use the same LOC determination methodology used in the respective State or territory in which the SNP is authorized to enroll eligible beneficiaries.
- (2) The MA organization must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective MA organization) with the requisite professional knowledge to accurately identify institutional LOC needs. Importantly, the entity cannot be owned or controlled by the MA organization.

20.3.3 - Change of Residence Requirement for I-SNPs

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

30 - General Requirements and SNP Payment Procedures

30.1 - General

SNPs are expected to follow existing MA program rules, including MA regulations at 42 CFR Part 422, as modified by guidance, with regard to Medicare-covered services and Prescription Drug program (PDP) rules. SNPs should assume that, if no modification is contained in these guidelines, existing MA and PDP rules apply. Additional requirements for SNP plans can be

found throughout the Medicare Managed Care Manual and the Prescription Drug Benefit Manual.

In general, SNPs are required to meet all applicable statutory and regulatory requirements that apply to MA plans, including:

- State licensure as a risk-bearing entity;
- *MA reporting requirements that are applicable depending on plan size (see Chapter 5 for the Medicare Managed Care Manual for information regarding SNP reporting requirements); and*
- Part D prescription drug benefit requirements.

Payment procedures for SNPs mirror the procedures that CMS uses to make payments to non-SNP MA plans. SNPs must prepare and submit a bid like other MA plans, and are paid in the same manner as other MA plans based on the plan's enrollment and risk adjustment payment methodology. Guidance on payment to MA organizations is available in Chapter 8 of the Medicare Managed Care Manual. We post current MA payment rates online in the “Rate books and supporting Data” section at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>.

30.2 - Application of Frailty Adjustment for Certain SNPs

Section 1853(a)(1)(B) of the Act gives the Secretary the authority to apply a frailty payment under Program of All-Inclusive Care for the Elderly (PACE) payment rules for certain FIDE SNPs described in Section 1853(a)(1)(B)(iv) of the Act and further defined in Section 40.4.3 of this chapter to reflect the costs of treating high concentrations of frail individuals. CMS annually announces its methodology for determining whether a FIDE SNP “has a similar average level of frailty ... as the PACE program” in its annual “Announcement of Calendar Year Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter” (Advance Notice). We also notify FIDE SNPs annually of their frailty score and how they compare to PACE. In accordance with the statutory requirement, we added a definition of FIDE SNPs at 42 CFR Section 422.2(3).

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 C.F.R. Section 422.2(3); and (2) have similar average levels of frailty as PACE organizations as described in the Advance Notice for the given year.

30.3 - Hierarchical Condition Categories (HCC) Risk Adjustment for C-SNPs

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)(i) 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. Refer to our annual Rate Announcements for a description of any

evaluation conducted during the preceding year and any revisions made under Section 1853(b) of the Act.

40 - Application and Approval Requirements

40.1 - General

The SNP application is located in Appendix I of the MA Application. Applicants that do not have a CMS contract and are requesting to offer a SNP must complete the MA application, including the SNP application. The timeline for submitting the SNP application is the same as the MA application timeline. The MA application and including the SNP application for the current contract year are available at <http://www.cms.hhs.gov/MedicareAdvantageApps/>.

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. All SNP applications must be submitted electronically through the Health Plan Management System (HPMS) to CMS by the MA application due date. CMS will not accept a SNP application submitted on paper.

Every applicant that proposes to offer a SNP must obtain additional CMS approval as a Medicare Advantage Prescription Drug (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 MA organization 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. We provide further guidance on SAE procedures in Section 40.4 of this chapter.

40.2 - Model of Care Approval

As provided under Section 1859(f)(7) of the Act, SNPs’ Models of Care (MOC) must be approved by the NCQA as of January 1, 2012. The MOC provides the basic framework to support the SNP in meeting the needs of each of its enrolled beneficiaries. The MOC is considered to be a vital quality improvement tool and integral component for ensuring that the unique needs of each enrolled beneficiary are identified and addressed. The MOC provides the needed infrastructure to promote quality, care management and care coordination processes for SNPs.

The statute gives the Secretary authority to establish standards for the approval process. The SNP approval process will provide a foundation for selecting MA organizations that comprehend the unique requirements of the SNP program and that are capable of implementing these requirements. The NCQA SNP approval process is based on scoring each of the clinical and non-clinical elements of the MOC as part of the SNP application.

(The current MOC and scoring methodology have been revised. Please note that detailed information regarding the SNP MOC elements and scoring criteria have been moved from this chapter and the final revised MOC and scoring methodology will be incorporated into Chapter 5 (“Quality Improvement Program”) of the Medicare Managed Care Manual. We believe that this information appropriately resides in that chapter, as it reflects the fundamental purpose of the MOC as an essential quality improvement tool for SNPs.

MOC Cure Process

CMS continues to raise the bar to ensure that SNPs submit high-quality MOCs. Therefore, as stated in our Final Call Letter, issued on April 2, 2012, beginning with CY 2014, we are limiting the number of “cures” offered for MOCs during the SNP approval process. SNPs that have a failing score (less than 70 percent) for their initial MOC submission will have one cure opportunity to achieve a score within the passing range of 70-74 percent. Regardless of the score following that cure opportunity (provided the score is at least 70 percent), those SNPs will only receive a one-year approval.

For CY 2014 and subsequent years, the following MOC approval requirements will apply:

- ***3-year approval:***
 - *SNPs that receive a score of 85 percent or higher on their initial MOC submission. There are no cure opportunities for these SNPs.*
- ***2-year approval:***
 - *SNPs that score between 75-84 percent on their initial MOC submission. There are no cure opportunities for these SNPs.*
- ***1-year approval:***
 - *SNPs that score between 70-74 percent on their initial MOC submission. There are no cure opportunities for these SNPs;*
 - *SNPs that score less than 70 percent on their initial MOC submission and subsequently attain a score of 70 percent or higher after they have had one opportunity to cure.*
- ***No approval: SNPs that score below 70 percent on their MOCs based on a single cure opportunity.***

Table 4 below summarizes the MOC review and cure process for MOCs for CY 2014 and subsequent years:

Table 4: Overview of MOC Review and Cure Processes

<i>Score for Initial MOC Submission (%)</i>	<i>Cure Options</i>	<i>Post 1st Cure</i>	<i>Final Approval Status</i>
<i>85% to 100%</i>	<i>No cure options</i>	<i>N/A</i>	<i>3-year approval</i>

<i>75% to 84%</i>	<i>No cure options</i>	<i>N/A</i>	<i>2-year approval</i>
<i>70% to 74%</i>	<i>No cure options</i>	<i>N/A</i>	<i>1-year approval</i>
<i>69% or below</i>	<i>One cure option</i>	<i>70% or higher</i>	<i>1-year approval</i>
<i>69% or below</i>	<i>One cure option</i>	<i>69% or below</i>	<i>No approval</i>

This policy provides added incentive for SNPs to develop and submit comprehensive and carefully considered MOCs for initial NCQA approval and continues to reward those SNPs that have demonstrated their ability to independently develop high-quality MOCs.

40.3 - Existing SNP Model of Care Re-Approval and Application Submissions

An MAO must submit a new SNP application and MOC only if one of the following scenarios applies:

- The MAO seeks to offer a new SNP (Chronic, Dual Eligible, or Institutional).*
- The MAO seeks to expand its existing service area.*
- An existing D-SNP anticipates contracting with a State Medicaid Agency to modify the dual eligible population(s) it currently targets Note: New D-SNPs must be classified as an “All-Dual D-SNP”, “Full Benefit D-SNP”, “Medicare Zero Cost-Sharing”, “Dual Eligible Subset”, or a “Dual Eligible Subset-Medicare Zero Cost-Sharing.”*

An MAO with an existing SNP that has a current one-year or multi-year MOC approval is not required to submit a SNP application; it must submit only the MOC in HPMS, with the associated attestations and upload matrix document.

40.4 - Service Area Expansion (SAE)

In general, an MA organization may continue to offer the same local MA plan benefit package (PBP) and add one or more new service areas (i.e., counties) to the plan’s service area in the following CY. If an MA organization is interested in expanding its service area and adding a SNP in the expanded service area, it must complete the MA SAE application and an SAE application for Part D. In addition, the MA organization must submit a new MOC even if the SAE application occurs within a currently approved multi-year cycle. If the MA organization does not have Part D coverage in the service area in which it is seeking to offer a SNP, it must file a Part D application in addition to the MA SAE application. The Part D application for MA-PD plans is posted at: <http://www.cms.hhs.gov/PrescriptionDrugCovContra>.

The service area of the proposed SNP cannot exceed the existing or pending service area for the MA contract. Refer to Section 40.4.2 of this chapter for additional guidance regarding SAE application requirements for D-SNPs.

40.4.1 - Service Area Requirements for I-SNPs

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 in terms of excluding either "sicker," lower-income or minority beneficiaries in its service area.

40.4.2 - Initial Application and SAE Requirements for D-SNPs

All MA organizations that request to operate in a new service area or to expand a service area of an existing D-SNP must have a contract with State Medicaid Agency(ies) in the State(s) in which the D-SNP plan operates. ***MA organizations should note that the service area(s) must match that in their State Medicaid contract. An MA organization seeking an SAE for a CMS-approved D-SNP must provide CMS with a copy of the State Medicaid contract and related information in its SNP application through the plan creation module in HPMS.*** Refer to annual guidance for the SNP application submission deadline for the current CY. ***All D-SNPs at the time of application must complete an attestation that it will submit a State Medicaid Agency contract by July 1 for the upcoming contract year.***

40.4.3 - Fully Integrated Dual Eligible (FIDE) SNPs

SNPs classified as Fully Integrated Dual Eligible (FIDE) are described in Section 1853(a)(1)(B)(iv) of the Act and at 42 CFR Section 422.2. FIDE SNPs are CMS-approved SNPs that:

- (1) 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 Section 422.2 and described in detail in Section 40.5.3 of this chapter;***
- (2) Provide dually-eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization;***
- (3) 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;***
- (4) 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 beneficiaries; and,***

(5) Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

As stated in number 3 above, the FIDE-SNP definition at 42 C.F.R. Section 422.2 requires the plan to have a contract with the applicable state(s) in its service area specifying that the state(s) will pay the FIDE-SNP a capitation payment for primary, acute, and long-term care Medicaid benefits and services in exchange for the FIDE-SNP's provision of these benefits to its enrollees. In determining whether a D-SNP meets the FIDE-SNP definition, CMS will allow Long Term Care benefit carve-outs or exclusions only if the plan can demonstrate that it meets the following criteria:

- (1) The plan must be at risk for substantially all of the services under the capitated rate;*
- (2) The plan must be at risk for nursing facility services for at least six months (180 days) of the plan year;*
- (3) The individual must not be disenrolled from the plan as a result of exhausting the service covered under the capitated rate; and,*
- (4) 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.

Refer to Section 30.2 in this chapter regarding frailty payment adjustment to certain D-SNPs that meet the FIDE SNP definition.

40.4.4 - Benefits Flexibility for Certain Dual Eligible Special Needs Plans

Regulations at 42 CFR Section 422.102(e) allow dual eligible special needs plans (D-SNPs) that meet a high standard of integration 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 beneficiaries who are at risk of institutionalization in the community. In order to meet the minimum contract requirements for purposes of qualifying for the benefits flexibility, the D-SNP must:

- Be a specialized MA plan for dually-eligible special needs individuals described in Section 1859(b)(6)(B)(ii) of the Act;*
- Be operational in the upcoming contract year and have operated the entire previous calendar year;*

- *Facilitate access to all covered Medicare benefits and all Medicaid benefits covered in the State Medicaid plan;*
- *Have a current capitated contract with a State Medicaid Agency that includes coverage of specified primary, acute, and long term care benefits and services to the extent capitated coverage is consistent with State policy;*
- *Coordinate delivery of covered Medicare and Medicaid primary, acute, and long term care services throughout its entire service area; and,*
- *Possess a valid contract arrangement with the State, in accordance with CMS policy and the requirements at 42 CFR Section 422.107.*

CMS will apply these contract design requirements at the individual SNP plan (i.e., SNP plan benefit package) level.

In order to meet the qualifying standards for benefits flexibility eligibility, the D-SNP must also:

- (1) *Have received a 3-year approval of its model of care most recently reviewed by the National Committee for Quality Assurance (NCQA); and*
- (2) *Either be in a contract with a current 3 star (or higher) overall rating on the Medicare Plan Finder website. If the D-SNP is part of a contract that does not have sufficient enrollment to generate a star rating, the ratings will be based upon the most recent SNP plan-level HEDIS measures. The plan must receive 75% 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.*

In addition, the D-SNP cannot be a poor performer, i.e., not be part of a contract with a score of 2 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.

40.4.5 - Types and Categories of Benefits CMS May Approve under the Benefit Flexibility

Additional Medicare supplemental benefits may not replace State Medicaid or local benefits for enrollees that are eligible to receive identical Medicaid services. Rather, D-SNPs are expected to use the flexibility to design their benefits in a way that adds value for the

beneficiary by augmenting and/or bridging a gap between Medicare and Medicaid covered services. Additional supplemental benefits that may be offered are most appropriate for individuals who need assistance with activities of daily living (ADLs). This may include, for example, eating, drinking, dressing, bathing, grooming, toileting, transferring, and mobility or instrumental activities of daily living, (IADLs), e.g., transportation, grocery shopping, preparing food, financial management, and taking medication correctly. D-SNPs that offer any new supplemental benefits under this provision must provide these benefits to the beneficiary at zero cost.

Qualified D-SNPs that choose to offer additional supplemental benefits must include the proposed benefit(s) as a part of their plan benefit packages (PBPs) during bid submission; CMS will approve the specific new supplemental benefit(s), as appropriate. The plan must attest, at the time of bid submission, that the additional 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 requires that qualified D-SNPs that choose to take advantage of the extra benefit flexibility submit a quality improvement project (QIP) on a topic related to the supplemental benefit proposed by the plan. CMS, in consultation with the plan, will determine the topic for that QIP.

Table 5 below sets forth guidance on specific categories of supplemental benefits that qualified D-SNPs are permitted to offer as part of the benefits flexibility initiative. CMS will update these categories as necessary, in time for plans to include the benefit(s) for an upcoming contract year.

Table 5: Supplemental Benefits for Consideration

<i>Proposed Benefit Category</i>	<i>Benefit Description</i>	<i>Acceptable Means of Delivery</i>	<i>PBP Description</i>
<i>Non-Skilled In-home Support Services 40.4.5</i>	<i>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</i>	<i>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</i>	<i>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.</i>

	<i>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</i>		
<i>In-Home Food Delivery</i>	<i>Meal delivery service (beyond the limited coverage described in Chapter 4 of the Medicare Managed Care Manual 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 as a result of a chronic condition.</i>	<i>Meals would be provided consistent with plan policies for ensuring nutritional content (e.g., minimum recommended daily nutritional requirements)</i>	<i>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, number of meals/day).</i>
<i>Supports for Caregivers</i>	<i>Provision of respite care – either through a personal care attendant or provision of short-term institutional-based care – for beneficiary caregivers. Coverage may include benefits such as counseling and training courses (related to the provision of plan-covered benefits) for caregivers</i>	<i>Specific caregiver support benefits must directly relate to the provision of plan-covered benefits.</i>	<i>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).</i>
<i>Home Assessments, Modifications, and Assistive Devices for Home Safety</i>	<i>Coverage of home safety/assistive devices, and home assessments and modifications beyond those permitted in Chapter 4, of the Medicare Managed</i>	<i>Home assessments would be performed by trained personnel (e.g., occupational therapists), or by persons with</i>	<i>Describe benefit comprehensively, and clearly distinguish safety assessments and devices already covered under</i>

	<i>Care Manual. Coverage may include items/services such as rails in settings beyond the beneficiary'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.</i>	<i>qualifications required by the State, if applicable.</i>	<i>Chapter 4 of the MMCM from additional benefits qualified SNPs could provide. Describe enrollee criteria for receiving these additional benefits (e.g., beneficiary at risk of falls, etc.)</i>
<i>Adult Day Care Services</i>	<i>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 service.</i>	<i>Provided by staff whose qualifications and/or supervision meet State licensing requirements.</i>	<i>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.)</i>

40.5 - Contracting Requirements

40.5.1 - State Contract Requirements for D-SNPs

As provided under Section 164(c)(2) of MIPPA, and as amended by Section 3205(d) of the ACA, D-SNPs that continue to operate in their existing service areas were not required to have a contract with their State Medicaid Agencies until January 1, 2013. Beginning January 1, 2013, all D-SNPs are required to have an executed contract with applicable State Medicaid agencies.

Note that the requirement for a State contract and the requirement for NCQA MOC approval discussed in Section 40.2 of this chapter are separate requirements. D-SNPs must meet both requirements in order to operate.

The SNP application, which is available through HPMS, provides further information on how and when D-SNPs must submit their State Medicaid Agency contracts 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. *Furthermore, any D-SNP that includes an "evergreen clause" in the State Medicaid Agency contract must submit its contract to CMS by the established due date. The D-SNP must include a letter from the State Medicaid Agency stating that it intends to continue contracting with the health plan for the upcoming calendar year.*

The contract with the State Medicaid Agency must document each entity's roles and responsibilities with regard to dual eligible individuals, and must cover the minimum regulatory requirements below:

(1) The MA organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits.

This contracting element requires that the process by which the D-SNP Agency provides and/or arranges for Medicaid benefits must 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 eligible beneficiaries to be enrolled under the D-SNP, including the targeting of specific subsets.

This contracting element requires that the contract clearly identify the dual-eligible population that is eligible to enroll in the D-SNP. A D-SNP may only enroll dual-eligible beneficiaries as specified in the State Medicaid Agency Contract. 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 MA organization may establish a D-SNP that limits enrollment to that same subset of dual eligibles. For MA organizations 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 that 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.

MA organizations offering D-SNPs must enforce limits on the enrolled dual eligible beneficiaries' out-of-pocket (OOP) costs. Meeting this contracting element requires that D-SNPs not impose cost sharing requirements on specified dual eligible individuals (i.e., FIDE individuals, QMBs, or any other population designated by the State) that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP.

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

This contracting element requires that the contract enumerate a process by which 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 Medicare and Medicaid networks should meet the needs of the dual eligible population served.

- (6) The verification process of an enrollee’s eligibility for both Medicare and Medicaid.
This contracting element requires that the State Medicaid Agency provide MA organizations with access to real-time information verifying eligibility of enrolled dual eligible members. The agreed upon eligibility verification process must be described in detail.
- (7) The service area covered under the SNP.
This contracting element requires that the contract clearly identify the covered service area(s) in which the State has agreed the MA organization may market and enroll. The D-SNP service area(s) must be consistent with the State Medicaid Agency contract approved service area(s).
- (8) The contracting period.
This contracting 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 may also be drafted as multi-year, or “evergreen” contracts (i.e., continuously valid until a change is made in the contract) so long as the entire calendar year is covered. In this case, the plan may indicate the evergreen clause within the contract and provide an explanation of when the State issues an update.

40.5.2 - Relationship to State Medicaid Agencies

Pursuant to Section 1859 of the Act, State Medicaid Agencies are not required to enter into contracts with MA organizations with respect to a SNP. However, if the MAO does have such a contract, the submission of the State Medicaid Agency contract to CMS does not relieve the MA applicant of the pre-existing MA application requirement to secure a license and certification from the State Department of Insurance to offer a MA product in the State.

40.5.3 - Limiting Enrollment to Dual Eligible Subsets under a State Contract

A D-SNP may target a population that is narrower than the populations of CMS’s defined D-SNP categories (i.e., Full Dual D-SNPs and Zero Cost-share D-SNPs) in order to coordinate services between the Medicare and Medicaid programs.

Any enrollment limitations for Medicare beneficiaries under this type of limited enrollment D-SNP must parallel any enrollment limitations under the Medicaid program, including the Medicaid program’s structure and care delivery patterns. For example, if a State Medicaid Agency contracts with a plan for a Medicaid wraparound package for certain dual eligibles (e.g., individuals aged 65 and above), an MA organization may establish a D-SNP that limits enrollment to that same subset of dual eligibles.

Further, the SNP must provide documentation to CMS regarding their contract and/or agreement with the State Medicaid Agency. If applicable, this would include verification that the subset of enrolled dual eligible beneficiaries will have zero-cost sharing for Medicare Part A, Part B, or Part D.

If an MA organization has been approved to offer a D-SNP for a subset population that is identified in the State contract, then, in order for the MA organization to continue offering such plan, it must have a signed State Medicaid Agency contract that is effective for the following year. The contract must be in place before the contract year begins, and must either overlap the entire CMS MA contract year, or contain an evergreen clause in the current contract that extends the contract.

40.5.4 - Procedures to Convert to another D-SNP Type

CMS will allow existing All Dual, Full Benefit Dual, Medicare Zero Cost-sharing, Dual Eligible Subset and Dual Eligible Subset Medicare Zero Cost-sharing D-SNPs to convert to another D-SNP type. Plans must request the conversion during the application period as part of a new SNP application. Submission of a new MA application is not required.

For these purposes, the following documents are required as part of the SNP application:

- (1) Completed State Medicaid Agency contract for implementation in the following contract year; and*
- (2) Contracting Review Matrix with the “Page Number(s)” and “Section Number” columns completed.*

The contracting review matrix and the guidance attached to the matrix must include instructions to ensure that the target population for the SNP matches the identified population in the State Medicaid contract.

An MAO currently offering a D-SNP PBP that has requested conversion to a different D-SNP type under the same MAO contract may transition current eligible enrollees into its newly created D-SNP PBP of the new SNP type. If the new D-SNP type has less restrictive eligibility requirements than the original D-SNP, the MAO may retain current eligible enrollees in the newly designated D-SNP PBP because all current enrollees will remain eligible for the new D-SNP with the new designation. Conversely, if the new D-SNP type has more restrictive eligibility requirements, such that a subset of D-SNP enrollees are no longer eligible for the D-SNP, those enrollees must be disenrolled to original Medicare (FFS Medicare) at the end of the contract year.

40.5.5 - Technical Assistance for States

CMS provides resources to assist States with coordination of Federal and State-based SNP policy in the following areas:

- Researching issues raised by States;
- Addressing State inquiries regarding State and Federal policy coordination;
- Soliciting and cataloguing relevant State materials; and,
- Creating communication forums for States to exchange ideas.

CMS established a Special Needs Plans State Resource Center to provide States with helpful information as they engage in contract negotiations with MA organizations seeking to offer new or expanded D-SNPs pursuant to the State contract requirement established at 42 CFR Section 422.107. The State Resource Center facilitates integration and coordination of benefits, policies, and day-to-day business processes between State Medicaid Agencies and D-SNPs. It supports State Medicaid agencies' efforts to improve Medicare-Medicaid benefit integration for their dual eligible populations, and provides a forum for States to make inquiries and share knowledge about the coordination of State and Federal policies pertaining to SNPs.

Plans may e-mail questions and information related to this topic to:

mailto:State_Resource_Center@cms.hhs.gov. The State Resource Center may be accessed on the Internet at

https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/index.html?redirect=/SpecialNeedsPlans/05_StateResourceCenter.asp

40.6 - Long-term Care (LTC) Facility Contract Requirements for I-SNPs

I-SNPs that serve residents of long-term care (LTC) facilities must own, operate, or have a contractual arrangement with the LTC facility that includes adherence ~~to~~ its approved I-SNP MOC. Contract requirements are described below:

- (1) Facilities in a chain organization must be contracted to adhere to the I-SNP MOC.
If the MA organization'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 access to I-SNP clinical staff.
The facility must agree to provide the I-SNP enrollees residing in the MA organization's contracted facilities with appropriate access to the applicant's SNP clinical staff including physicians, nurses, nurse practitioners and care coordinators, in accordance with the I-SNP protocols for operation.
- (3) Facilities must provide protocols for the I-SNP MOC.
The MA organization must agree to provide protocols to the facility for serving the beneficiaries enrolled in the I-SNP in accordance with the approved I-SNP MOC. These protocols must be referenced in the SNP's contract with the facility.
- (4) Delineation of services provided by the I-SNP staff and the LTC facility staff must be specified.
A delineation of the specific services provided by the MA organization's SNP staff and the facility staff to the I-SNP enrollees in accordance with the protocols and payment for the services provided by the facility.
- (5) Training plan for LTC facility staff to understand the MOC must be included.
A training plan to ensure that LTC facility staff understand their responsibilities in accordance with the approved I-SNP MOC, protocols and contract. If the training plan is a separate document, it should be referenced in the contract.

(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) 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 MA organization may also contract with additional LTC facilities throughout the CMS contract cycle.

(8) Grounds for early termination and transition plan for beneficiaries enrolled in I-SNP must be specified.

The termination clause must clearly state any grounds for early termination of the contract. The contract must include a clear plan for transitioning the beneficiary should the MA organization's contract with the LTC facility terminate.

40.7 - C-SNP Plan Benefit Packages (PBPs)

40.7.1 - Targeted Plan Benefit Packages (PBPs)

A C-SNP should have specific attributes beyond that of a standard MA CCP, in order to receive the special designation and marketing and enrollment accommodations. (See Section 70, below, and Chapter 3 of the Medicare Managed Care Manual, for more information on SNP-specific marketing.) C-SNPs are expected to have specially-designed PBPs that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all CCPs.

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

- (1) Supplemental health benefits specific to the designated chronic condition (e.g., diabetic testing supplies);
- (2) Specialized provider networks (e.g., physicians, home health, hospitals, etc.) specific to the designated chronic conditions); and,
- (3) Appropriate enrollee cost sharing structured around the designated chronic conditions and co-morbidities for all Medicare-covered and supplemental benefits.

40.7.2 - Grouping Chronic Conditions in PBPs

CMS has revised the automated SNP application section of the MA application to expand options at the point of application. When completing the SNP application, MA organizations can choose to offer a C-SNP that targets any one of the groups below:

- (1) A single CMS-approved chronic condition;

- (2) A CMS-approved group of multiple chronic conditions; or,
- (3) An MA organization-customized grouping of multiple chronic conditions selected from the 15 CMS-approved SNP-specific chronic conditions.

A C-SNP cannot be structured around multiple common co-morbid conditions that are not clinically linked in their treatment because this arrangement, by its very nature, leads to a general market product rather than a product tailored for a particular population. However, we recognize that certain chronic conditions are commonly co-morbid and clinically linked. We also know that some MA organizations presently operating a C-SNP serving multiple chronic conditions, in the interest of maintaining continuity for beneficiaries and their own operations, wish to maintain these multi-condition C-SNPs.

Therefore, CMS allows C-SNPs to target a group of multiple chronic conditions under two scenarios:

- (1) A CMS-designated grouping of commonly co-morbid and clinically linked conditions; or,
- (2) An MA organization-customized multiple-conditions option.

We describe both of these types of multiple-condition grouping scenarios in Sections 40.7.3 and 40.7.4 of this chapter.

40.7.3 - Commonly Co-morbid and Clinically-Linked Conditions

C-SNPs will be permitted to target a group of multiple chronic conditions in cases where the conditions are commonly co-morbid and clinically linked, based on the determination criteria below:

- The conditions in question are, based upon CMS's data analysis, determined to be commonly co-morbid; and,
- The conditions in question are, based upon recognized national guidelines such as those listed in the Guidelines Clearinghouse maintained by AHRQ, clinically linked in terms of treatment.

Based on an analysis of commonly co-existing chronic conditions in the current Medicare population, CMS will accept applications with the following multi-condition groupings:

Group 1: Diabetes mellitus and chronic heart failure;

Group 2: Chronic heart failure and cardiovascular disorders;

Group 3: Diabetes mellitus and cardiovascular disorders;

Group 4: Diabetes mellitus, chronic heart failure, and cardiovascular disorders; and,

Group 5: Stroke and cardiovascular disorders.

For MA organizations that are approved to offer a C-SNP targeting one of the above-listed groups, beneficiaries need only to have one of the qualifying conditions for enrollment. CMS will review the MOC, provider network, and benefits package specified in the application for the multi-condition SNP to determine adequacy in terms of creating a specialized product for the chronic conditions it serves.

40.7.4 - Beneficiaries with All Qualifying Conditions

MA organizations may develop their own multi-condition SNP combinations for enrollees with all of the qualifying chronic conditions in the combination. MA organizations that pursue this customized option must verify that enrollees have all of the qualifying conditions in the combination. MA organizations 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 40.7.3, 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, provider network and benefit package.

50 - SNP Enrollment Requirements

50.1 - General

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 dual-eligible" population may not enroll an individual who is not qualified as a full dual eligible even though he 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, beneficiaries who are dual eligible and who also 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 qualifying characteristic(s) of the SNP. Limits on enrollment, whether specific to persons with Medicare or for any individual eligible to enroll in the SNP, are not permissible, as MAOs must accept, without restriction, all individuals eligible to enroll. This is described in 42 CFR Section 422.60 and Section 1851(g)(1) of the Act.

All SNPs are required to verify the applicant's special needs status according to the requirements outlined in Chapter 2 of the Medicare Managed Care Manual. SNPs must include elements on the enrollment request mechanism that correspond to the special needs focus of the particular SNP. Refer to policy regarding enrollment request mechanisms, including special guidance for C-SNPs, in Chapter 2 of the Medicare Managed Care Manual.

Although MA organizations must accept enrollment through the Online Enrollment Center (OEC), SNPs may choose whether they wish to enroll beneficiaries through the OEC. Additional guidance on enrollment processes is available in Chapter 2 of the Medicare Managed Care Manual. Refer to Section 50.2 of this chapter and Chapter 2 of the Medicare Managed Care Manual for more information about C-SNP eligibility verification processes. Chapter 2 of the Medicare Managed Care Manual also includes information about Special Enrollment Periods (SEPs) for dual eligible individuals or individuals who lose their dual eligibility.

50.2 - Verification of Eligibility for SNPs

50.2.1 – Verification of Eligibility for D-SNPs

A D-SNP must confirm both 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 Chapter 2 of the Medicare Managed Care Manual.

50.2.2 – Verification of Eligibility for I-SNPs/Level of Care (LOC) Assessment for Institutional Equivalent SNPs

When an I-SNP opts to enroll a beneficiary before she/he has received at least 90 days of institutional level of care, 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 level of care will be at least 90 days. Examples of sources of information that CMS considers to be appropriate for this purpose include: a State LOC assessment tool, current MDS data, or a letter from the nursing facility on the organization's letterhead stating that the nursing facility expects the beneficiary to require a stay in excess of 90 days.

Pursuant to Section 1859(f)(2) of the Act, I-SNPs that are designated for individuals living in the community and requiring an institutional level of care (LOC) may only enroll individuals who 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 beneficiaries who reside in a specific ALF or continuing care community, a potential enrollee must agree to reside in the MA organization'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.

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

- (1) The State LOC assessment tool; and,
- (2) The entity performing the LOC assessments

The assessments must be performed by an entity unrelated to the MA organization. This independent entity may not be an employee of the MA organization 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.

MA organizations 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 40 of this chapter for further information regarding the SNP application submission.

50.2.2.3 – Verification of Eligibility for C-SNPs

All SNPs are expected to verify the applicant's special needs status according to the requirements outlined in Chapter 2 of the Medicare Managed Care Manual. 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.

Verification of eligibility can be in the form of a documented telephone contact with the provider confirming that the individual has the condition *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 beneficiary's diagnosed chronic condition(s) from a list of the conditions of interest to the C-SNP. The C-SNP should attempt to obtain eligibility verification information from a beneficiary's existing provider using methods other than phone contact. (Note that End Stage Renal Disease (ESRD) C-SNPs may use a physician-signed CMS Form 2728 ESRD Evidence Report as verification of the chronic condition.)*

An MA organization may request CMS approval to use a Pre-enrollment Qualification Assessment Tool in its process for verifying a beneficiary'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 beneficiary and includes a signature line for a physician or other qualified provider to confirm the beneficiary's eligibility for C-SNP enrollment. This tool may be used as the basis for enrolling a beneficiary, 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 during 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 enrolled beneficiary within the first seven calendar days of the second month of enrollment that he/she will be disenrolled at that second month.

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

- (1) 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 beneficiary has the applicable condition(s).
- (2) The MA organization 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.
- (3) The MA organization conducts a post-enrollment confirmation of each enrollee's information and eligibility using medical information provided by the enrollee's existing, or plan provider.
- (4) The MA organization ensures that any payment or compensation associated with enrollments will be forfeited if the qualifying chronic condition(s) cannot be confirmed.
- (5) 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 beneficiary's existing or plan provider during the first month of enrollment must notify the beneficiary 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.
- ~~(6) 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.~~
- (6) The MA organization 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 to be available upon request by CMS.
- (7) 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.

A request for CMS approval to use a Pre-enrollment Qualification Assessment Tool and a copy of the tool must be submitted by e-mail to: SNP_Mailbox@cms.hhs.gov. Enter “Pre-enrollment Qualification Assessment Tool” in the subject line along with the applicable H number.

50.3 - Waiver to Enroll Individuals with ESRD

A SNP may enroll individuals with End-Stage Renal Disease (ESRD) if it has obtained a waiver to be open for enrollment to individuals with ESRD. This waiver should be requested as part of the SNP application and is available to all types of SNPs, not just limited to C-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).

Applicants requesting an ESRD waiver must complete an upload document as part of the SNP application. The upload asks the applicant to provide information on a number of topics, including:

- ***A description of how the applicant intends to monitor and serve the unique needs of the ESRD enrollees, including their care coordination.***
- ***A listing of any additional service(s) provided to members 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., beneficiary, family, caregiver)***
 - ***Self-care education (e.g., nutrition, wound care)***
- ***A description of the interdisciplinary care team’s coordination role in the assessment and delivery of services needed by members with ESRD.***
- ***A listing of the contracted nephrologist(s). Beneficiary access to contracted nephrologists must meet the current HSD criteria.***
- ***A listing of the contracted dialysis facility(ies). Beneficiary access to contracted dialysis facilities must meet the current HSD criteria.***
- ***A description of the dialysis options available to beneficiaries (e.g., home dialysis; nocturnal dialysis).***
- ***A listing of the contracted kidney transplant facility(ies).***
- ***A description of beneficiary access to contracted kidney transplant facility(ies), including the average distance beneficiaries 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 beneficiaries at the time of application must submit a new SNP application if they propose to begin enrolling ESRD beneficiaries. Refer to Section 40 of this chapter for further guidance on the SNP application process. Once a waiver is approved, the SNP must allow all eligible ESRD beneficiaries—and only those beneficiaries—to enroll, in accordance with the guidance outlined in Chapter 2 of the Medicare Managed Care Manual.

50.4 - Continued Eligibility Requirements When A Beneficiary Loses Special Needs Status

Loss of eligibility is most often associated with D-SNP enrollment because, unlike chronic and disabling conditions that are the bases for special needs status for enrollment into C-SNPs and I-SNPs, a D-SNP enrollee's eligibility for enrollment is based on his/her dual eligibility for Medicare and Medicaid. Medicaid eligibility is subject to changes due to variation in the enrollee's income from one month to another or to changes in the State's criteria for eligibility. Thus, a dual eligible enrollee of a D-SNP may become ineligible for the plan due to the loss of his/her Medicaid eligibility for a period of time that may be one, or more months in duration.

If a SNP has no reasonable expectation that an enrolled beneficiary who has lost his/her special needs status will regain that status within a short period (not to exceed six months), the SNP must disenroll the individual from the SNP in accordance with guidance in Chapter 2 of the Medicare Managed Care Manual. The SNP may not retain the enrollee unless the expected period of loss of eligibility is six months or less. The SNP may choose any length of time from one month to six months for deeming continued eligibility, as long as the SNP applies the criteria consistently across all enrollees and fully informs enrollees of its policy. Refer to Chapter 2 of the Medicare Managed Care Manual for more information about deeming continuous eligibility.

Consistent with Chapter 2 of the Medicare Managed Care Manual, for the period of deemed continuous eligibility, an MA organization sponsoring a D-SNP must continue to provide all appropriate MA plan covered benefits as included in the approved plan bid. 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 otherwise be liable.

50.5 - Special Enrollment Period (SEP) for Individuals Losing Special Needs Status to Disenroll from SNP

CMS provides a SEP for individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status. SNPs must send the appropriate notice to the beneficiary explaining the disenrollment. Refer to Chapter 2 of the Medicare Managed Care Manual for additional guidance on SEPs for these individuals.

50.6 - Open Enrollment Period for Institutionalized Individuals

An open enrollment period for institutionalized individuals (OEPI) is available for individuals who meet the definition of “institutionalized individual” to enroll in or disenroll from an I-SNP. Refer to Chapter 2 of the Medicare Managed Care Manual for further information about the OEPI.

50.7 - Seamless Conversion Enrollment Option for Newly Medicare Advantage Eligible Individuals

MA organizations may develop processes to provide seamless enrollment in an MA plan for newly MA eligible individuals who are currently enrolled in other health plans offered by the MA organization, such as commercial or Medicaid plans, at the time of their conversion to Medicare. For example, an MA organization may request to enroll a current Medicaid member in a D-SNP. CMS will review an organization’s proposal and must approve it before use. MA organizations using the seamless enrollment option must provide the individual with clear instructions on how to opt-out, or decline, the seamless conversion enrollment. MA organizations must send proposals to the appropriate **CMS Regional Office Account Manager** and must meet the conditions provided in Chapter 2 of the Medicare Managed Care Manual.

60 - Disenrollment

60.1 - General

SNP enrollees who lose special needs status must be notified and disenrolled from the SNP, if necessary, in accordance with the requirements described in Chapter 2 of the Medicare Managed Care Manual.

60.2 - Transitioning Enrollees from Renewing and Non-Renewing D-SNPs

Table 6 below provides an overview of CMS policy for D-SNP renewals and non-renewals in several exceptional circumstances.

Note that, beginning in CY 2013, 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’ non-renewal instructions outlined in Table 6 below and in Chapter 4 of the Medicare Managed Care Manual. Beneficiaries in these plans will be disenrolled from their D-SNP and receive services under into Original Medicare. These individuals, by virtue of their dual eligible status, have an ongoing special election period and will be automatically enrolled in a benchmark PDP.

Table 6: Guidance for D-SNP Renewals/Non-Renewals

Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
Renewing D-SNP that also creates new Medicaid subset D-SNP and transitions eligible enrollees into the new Medicaid subset D-SNP	<p>For D-SNPs only: An MAO renewing a D-SNP plan for the upcoming Calendar Year (CY) and also creating a new Medicaid subset D-SNP for the upcoming CY. A subset of current enrollees under the renewing D-SNP is eligible to be enrolled in the new Medicaid subset D-SNP. The organization must submit enrollment transactions to move the eligible D-SNP enrollees into the new Medicaid subset D-SNP.</p>	<p>Exceptions Crosswalk Request: Organizations cannot complete the transition of current eligible enrollees to the new Medicaid subset D-SNP via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions.</p> <p>HPMS Plan Crosswalk Definition: An upcoming CY D-SNP that links to a previous CYD-SNP and retains all of its plan service area from the previous CY. The upcoming CY plan must retain the same plan ID as the previous CY plan. In addition, a new Medicaid subset plan is added for an upcoming CY that is not linked to a previous CY plan.</p> <p>HPMS Plan Crosswalk Designation:</p>	<p>The renewal PBP ID must remain the same so that the HPMS Plan Crosswalk will indicate that beneficiaries remain in the same PBP ID.</p> <p>The MAO must submit enrollment transactions to transition eligible current enrollees into the new Medicaid subset D-SNP. Individual enrollees not transitioned by the submission of enrollment transactions will remain enrolled in the renewing PBP.</p>	<p>No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in the upcoming CY.</p> <p>New enrollees must complete enrollment request.</p>	<p>Current enrollees transitioned to the renewal plan receive a standard ANOC. Current enrollees who are transitioned to the new Medicaid subset PBP receive a standard ANOC.</p>

Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
		Renewal Plan (renewing D-SNP designation) AND New Plan (new Medicaid subset D-SNP designation)			
Renewing D-SNP in a multi-State service area with a SAR to accommodate State contracting efforts in portions of that service area	For D-SNPs only: An MAO reduces the service area of a previous CY D-SNP PBP to accommodate State contracting efforts in a multi-State service area. Current enrollees in the reduced portion of the service area are transitioned to one or more new or renewing upcoming CY D-SNP PBPs. The organization must submit enrollment transactions to move current enrollees in the reduced portion of the previous CY D-SNP PBP into the new or renewing upcoming CY D-SNP PBPs.	Exceptions Crosswalk Request: Organizations cannot complete the transition of current enrollees to one or more new or renewing upcoming CY D-SNP PBPs via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. HPMS Plan Crosswalk Definition: An upcoming CY plan that links to a previous CY plan and only retains a portion of its plan service area. The upcoming CY plan must retain the same plan ID as the previous CY plan. In addition, a new plan(s) is added for the upcoming CY that is not linked to a previous CY	The renewal PBP ID must remain the same so that the HPMS Plan Crosswalk will indicate that beneficiaries remain in the same PBP ID. The MAO must submit enrollment transactions to transition current enrollees in the reduced portion of the service area into a new or renewing D-SNP. Individual enrollees not transitioned by the submission of enrollment transactions will remain enrolled in the renewing PBP.	No enrollment request is required for current enrollees in the remaining portion of the service area to remain enrolled in the renewal PBP in the upcoming CY. New enrollees must complete enrollment request.	Current enrollees in the renewal portion of the service area receive the standard ANOC. Current enrollees in the reduced portion of the service area who are transitioned to a new or renewal D-SNP PBP receive the standard ANOC.

Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
		<p>plan(s), is renewed in the upcoming CY.</p> <p>HPMS Plan Crosswalk Designation: Renewal Plan with a SAR AND/OR New Plan AND/OR Renewal Plan</p>			
<p>D-SNP that transitions current enrollees to a new D-SNP with a different designation and less restrictive eligibility requirements.</p>	<p>For D-SNPs only: An MAO offering a previous CY D-SNP PBP that requests conversion to a different D-SNP type for upcoming CY. The new D-SNP has less restrictive eligibility and all current enrollees remain eligible for the new D-SNP with the new designation.</p>	<p>Exceptions Crosswalk Request: Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization.</p> <p>HPMS Plan Crosswalk Definition: The previous CY D-SNP must be marked as a terminated plan in the HPMS Plan Crosswalk. The new upcoming CY D-SNP must be active and contain the applicable service area from the terminated plan being transitioned.</p>	<p>The MAO does not submit enrollment transactions for current enrollees.</p>	<p>No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in the upcoming CY. New enrollees must complete enrollment requests.</p>	<p>Current enrollees are sent a standard ANOC.</p>
<p>D-SNP that transitions some current enrollees to a new D-SNP with a different designation and more restrictive eligibility requirements</p>	<p>For D-SNPs only: An MAO offering a previous CY D-SNP PBP that requests conversion to a different D-SNP type for the upcoming</p>	<p>Exceptions Crosswalk Request: Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf</p>	<p>The MAO does not submit enrollment transactions for current enrollees who will be transitioned to the new D-SNP. The MAO submits</p>	<p>No enrollment request is required for current enrollees to remain enrolled in the new PBP in the upcoming CY. New enrollees must complete enrollment</p>	<p>Current enrollees who remain eligible for the renewing plan receive a standard ANOC. The MAO sends a CMS</p>

Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
consistent with the new D-SNP's State contract.	CY. The new D-SNP has more restrictive eligibility criteria. A subset of current enrollees is eligible to remain enrolled in the new upcoming CY D-SNP.	of the organization. HPMS Plan Crosswalk Definition: The previous CY D-SNP must be marked as a terminated plan in the HPMS Plan Crosswalk. The new upcoming CY D-SNP must be active and contain the applicable service area from the terminated plan being transitioned.	disenrollment transactions for current enrollees who are ineligible for the new D-SNP.	requests.	model disenrollment notice to ineligible current enrollees who are to be disenrolled, which will convey information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.

70 - Marketing

70.1 - General

As with any MA organization, MA SNPs must market to all individuals eligible to enroll in the plan. For example, if an MA SNP is developed for institutionalized beneficiaries at select skilled nursing facilities (SNFs), the MA SNP must market to all Medicare Part A and/or Part B beneficiaries residing in those SNFs. D-SNPs may wish to work with their respective States to identify an acceptable method of targeting dual eligible beneficiaries.

~~—CMS Medicare Marketing Guidelines do not apply to marketing materials created by State governments; therefore, those materials do not need to be reviewed or submitted in HPMS. Refer to Chapter 3 of the Medicare Managed Care Manual for further information on marketing requirements for SNPs.~~

~~There are certain marketing provisions specifically related to providers, such as allowing providers to feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider's affiliation or arrangement with a SNP by placing the SNP affiliations at the beginning of the announcement and may include specific information about the SNP (e.g., special plan features, the population the SNP serves, specific benefits for each SNP). This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated. Refer to Chapter 3 of the Medicare Managed Care Manual for further information on marketing requirements for SNPs.~~

~~70.1.1 – Marketing Exception for D-SNPs~~

~~The standardized, combined Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) is due to current members of all MA plans, MA-PD plans, PDPs, and 1876 cost-based plans that offer Part D by September 30 of each year. Organizations are not required to mail the Summary of Benefits (SB) to existing members when using the combined, standardized ANOC/EOC; however, the SB must be available upon request.~~

~~Exception: D-SNPs may choose to send the ANOC for member receipt by September 30 and the EOC for member receipt by December 31. D-SNPs that choose this option must also send an SB with the ANOC. Refer to Chapter 3 of the Medicare Managed Care Manual for further information on marketing exceptions for D-SNPs.~~

~~70.2 – Comprehensive Written Summary of Benefits Statement for D-SNPs~~

~~Pursuant to Section 1859(f)(3)(C) of the Act, plan sponsors offering D-SNPs must provide each prospective enrollee, prior to enrollment, with a comprehensive written Summary of Benefits statement that includes a comparison of cost sharing protections between the SNP and the relevant State Medicaid plan. The comprehensive written statement must include all the elements described below:~~

- ~~• The benefits that the individual is entitled to under Title XIX (Medicaid);~~
- ~~• The cost sharing protections that the individual is entitled to under Title XIX (Medicaid); and,~~
- ~~• A description of the benefits and cost sharing protections that are covered under the D-SNP for dual eligible individuals.~~

~~Further guidance on submission of the comprehensive written statement is available in Chapter 3 of the Medicare Managed Care Manual.~~

~~70.3 – Special Requirements for I-SNPs~~

~~Marketing materials and outreach for new enrollment must clearly indicate that enrollment is limited to the targeted population for the particular SNP type. Further guidance on marketing within a health care setting and other SNP marketing policies is available in Chapter 3 of the Medicare Managed Care Manual.~~

80 - Covered Benefits

80.1 - Part D Coverage Requirement

All SNPs must include required Part D prescription drug coverage, regardless of whether the MA organization offers a CCP in the area with Part D benefits. Refer to Chapter 4 of the Medicare

Managed Care Manual for more information about this requirement.

80.2 - SNP-specific PBPs

CMS expects MA organizations offering SNPs to begin with a well-developed MOC, structure their service delivery system to support this model, and design their PBP to address the specialized needs of the targeted beneficiaries. In addition, SNP-specific PBPs should incorporate some or all benefits that exceed the basic required Medicare A and B benefits offered by other MA products available in the same service area.

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

- 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);
- Social services (e.g., connection to community resources for economic assistance); transportation services; and,
- Wellness programs to prevent the progression of chronic conditions.

Plans should note that some social-support services (e.g., in-home support services) may not be approved in bids as Medicare supplemental benefits, and proposed supplemental benefits must be consistent with our guidance in Chapter 4 of the Medicare Managed Care Manual.

CMS will continue to analyze the SNP PBPs to identify best practices and recommendations for designing PBPs 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 MA organizations before approving SNP PBPs.

80.3 - Meaningful Difference in Plan Benefits

To determine whether SNPs satisfy the meaningful difference requirement outlined in Chapter 4 of the Medicare Managed Care Manual, we separate SNPs into groups representing the various allowed SNP types (i.e., C-SNP, I-SNP, D-SNP). SNPs are further separated into narrower groups and evaluated on the meaningful difference criteria 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; and,
- D-SNPs: Excluded from the meaningful difference evaluation.

CMS evaluates meaningful differences among plans offered in the same county by a parent organization. Each year, CMS calculates the combined Part C and Part D (if applicable) out-of-pocket cost (OOPC) estimate for each PBP within the plan-type groups, and determines a total OOPC difference that plans must have in order to be considered meaningfully different. The calculation includes Parts A, B, and D services and mandatory supplemental benefits, but not optional supplemental benefits. CMS releases the OOPC threshold amount through guidance each year before plans submit their bids for the following contract year.

Plan bids that do not meet the meaningful difference requirements and those outlined in Chapter 4 of the Medicare Managed Care Manual will not be approved by CMS. Although CMS will not prescribe how plans should redesign their plan benefits packages (PBPs) to achieve the differences, plans are expected to meet the meaningful difference requirements in the initial bid submitted to CMS for the contract year, and may not be permitted to revise submissions if the initial bid does not comply with meaningful difference requirements.

80.4. – Special Cost Sharing Requirements for D-SNPs

80.4.1 – General

MA organizations offering D-SNPs may provide Medicaid benefits directly, or under contract with another entity, but must retain responsibility for the benefits. States and MA organizations may identify the package of Medicaid benefits included in the D-SNP through their contract negotiations. The contract should include the limitation on OOP costs for full benefit dual eligible individuals or qualified Medicare beneficiaries when these dual eligible categories are covered in its plan. We encourage States and MA organizations to move towards more complete integration of Medicare and Medicaid benefits for dual-eligible individuals in SNP products.

80.4.2 - Cost sharing Requirements for D-SNPs

MA organizations offering D-SNPs must enforce limits on OOP costs for dual eligible individuals. Pursuant to Section 1852(a)(7) of the Act and 43 CFR Section 422.504(g)(1), D-SNPs cannot impose cost sharing requirements on specified dual eligible individuals (FBDEs, QMBs or any other population designated by the State) that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP. This category includes QMBs and QMB+, the two categories of dual eligible beneficiaries that have all Medicare Part A and Medicare Part B cost sharing paid by Medicaid, and may also include other dual eligible beneficiaries that the State holds harmless for Part A, Part B, or Part D cost sharing.

Like all other local MA plans, D-SNPs must establish a maximum out of pocket (MOOP) limit to provide this enrollee protection even though the State Medicaid program is usually paying

those costs on the enrollee's behalf. CMS requires D-SNPs to establish annual MOOP limits because an enrollee's eligibility for Medicaid may change during the year, leaving the enrollee liable for cost sharing. In this circumstance, the State Medicaid program would not be expected to pay more than the MOOP amount it would pay if it were responsible for the enrollee's cost sharing. We strongly encourage D-SNPs to establish MOOP amounts that are greater than \$0 to protect the plan from full liability for the cost sharing amounts in the event that an enrollee's Medicaid coverage is discontinued for some period of time. However, we permit plans to adopt a \$0 MOOP.

Although it may be rare that an enrollee of a D-SNP would be responsible for paying any cost sharing because the State Medicaid program is making those payments on his behalf, the PBPs for D-SNPs must reflect the plan's actual out-of-pocket cost sharing charges for covered services as well as a valid MOOP amount. For purposes of tracking out-of-pocket spending relative to its MOOP limit, a plan must count only the actual OOP expenditures for which each enrollee is responsible. Thus, for any dual eligible enrollee, MA plans must count toward the MOOP limit only those amounts the individual enrollee is responsible for paying net of any State responsibility or exemption from cost sharing and not the cost sharing amounts for services the plan has established in its PBP. Effectively, this means that, for those dual eligible enrollees who are not responsible for paying the Medicare Parts A and B cost sharing, the MOOP limit will rarely be reached. However, plans must still track OOP spending for these enrollees. Any D-SNP type, other than a zero dollar-cost share D-SNP, must also indicate the cost sharing range for the plan in the plan's (SB). Refer to our latest Call Letter to Medicare Advantage Organizations for guidance on SB changes reflecting D-SNP cost sharing requirements available at:

<http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2014Announcement.html?DLPage=1&DLSort=2&DLSortDir=descending>

80.4.3 - Cost sharing for Dual Eligible Beneficiaries Requiring an Institutional Level of Care

As provided under Section 1860D-14 of the Act, full-benefit dual eligible institutionalized individuals have no cost sharing for covered Part D drugs under their PDP or MA-PD plan. Effective January 1, 2012, Section 1860D-14 of the Act also eliminates Part D cost sharing for full-benefit dual eligible 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 are targeted to frail, elderly individuals who, without the delivery in their home of services such as personal care services, would be at risk of institutionalization. HCBS eligibility

is not based on where an individual resides. In other words, SNPs cannot assume that all beneficiaries residing in assisted living facilities receive HCBS and therefore qualify for the \$0 cost sharing. Thus, in order to receive the waiver under Section 3309, a SNP must determine or a beneficiary must demonstrate that s/he is a full-benefit dual eligible individual receiving HCBS under Title XIX. Below, we list of acceptable documents that may be used as best available evidence (BAE) for demonstrating receipt of HCBS:

- A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary'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 beneficiary'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 beneficiary'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.

90 - Quality Improvement

SNPs have the same performance improvement requirements as other coordinated care plans; however, such requirements are tailored to the special needs individuals that the SNP serves. Pursuant to 42 CFR Section 422.152(c)-(g), SNPs must conduct both a Chronic Care Improvement Program (CCIP), a Quality Improvement Project (QIP) targeting the special needs population that it serves, and must submit their Models of Care (MOC) to CMS for NCQA evaluation and approval. Refer to Chapter 5 of the Medicare Managed Care Manual for further guidance on SNP quality improvement and reporting requirements.