CMS Manual System
Pub. 100-16 Medicare Managed Care

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

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SUBJECT: Update to Section 20.2.1 and 20.2.5-20.2.7 on the definitions of dual eligible special needs plans (D-SNPs) and additional requirements for certain D-SNPs

I. SUMMARY OF CHANGES: The updated section now better reflects current regulatory requirements. Changes are as follows:

- We added language to define D-SNPs, HIDE SNPs, CO SNPs, and applicable integrated plans and amended language defining FIDE SNPs
- We updated the section on frailty adjustments for D-SNPs
- We added a new section describing Medicaid carve-outs
- We added a new section describing D-SNP only contracts

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 12, 2024
IMPLEMENTATION DATE: January 12, 2024

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

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	TOC
R	20.2.1 – General Definitions
N	20.2.1.1 – Eligibility Definitions
N	20.2.1.2 – D-SNP Definitions
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N	20.2.7.2 – State Notification to CMS
N	20.2.7.3 – Integrated Materials

N	20.2.7.4 – Joint State/CMS Oversight
N	20.2.8 – Benefit Flexibility for Certain D-SNPs
N	20.2.8.1 – Benefit Flexibility Eligibility Requirements
N	20.2.8.2 – Characteristics and Categories of Flexible Supplemental Benefits
N	20.2.8.3 – Benefit Flexibility Approval Process

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

IV. ATTACHMENTS:

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

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

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

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(Rev. 130, Issued: 01-12-24)

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10 – Introduction

10.1 – General

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

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

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

Table 1: Chapter Sections Applicable to Certain SNP Types

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

10.2 – Statutory and Regulatory History

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

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

The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 subsequently extended the SNP program from December 31, 2008, to December 31, 2009, but imposed a moratorium that prohibited CMS from approving new SNPs after January 1, 2008. Accordingly, CMS did not accept SNP applications in 2008 for contract year (CY) 2009.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) lifted the Medicare,

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

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

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

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

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

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

10.3 – Requirements and Payment Procedures

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

SNPs are expected to follow existing MA program rules, including MA regulations at 42 CFR 422, as interpreted by guidance, with regard to Medicare-covered services and Prescription Drug Benefit program rules. All SNPs must provide Part D prescription drug coverage because special needs individuals must have access to prescription drugs to manage and control their special health care needs (see 42 CFR 422.2). SNPs should assume that existing Part C and D rules apply unless there is a specific exception in the regulation/statutory text or other guidance to CMS interpreting the rule as not applicable to SNPs. Additional requirements for SNP plans can be found in the Prescription Drug Benefit Manual at: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html.

Payment procedures for SNPs mirror the procedures that CMS uses to make payments to non-SNP MA plans. SNPs must prepare and submit bids like other MA plans, and are paid in the same manner as other MA plans based on the plan's enrollment and the risk adjustment payment methodology. Guidance on payment to MAOs is available in chapter 8 of the MMCM. CMS posts

current MA payment rates online in the "Ratebooks & Supporting Data" section at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

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

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

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

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

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

C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. Approximately two-thirds of Medicare enrollees have multiple chronic conditions requiring coordination of care among primary providers, medical and mental health specialists, inpatient and outpatient facilities, and extensive ancillary services related to diagnostic testing and therapeutic management.

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

20.1.2 – List of Chronic Conditions
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

Section 1859(b)(6)(B)(iii) of the Act and 42 CFR 422.2 define special needs individuals with severe or disabling chronic conditions as special needs individuals "who have one or more co-morbid and medically complex chronic conditions that are substantially disabling or life threatening; have a high risk of hospitalization or other significant adverse health outcomes; and require specialized delivery systems across domains of care." CMS solicited public comments on chronic conditions meeting the clarified definition and convened the SNP Chronic Condition Panel in the fall of 2008. Panelists included six clinical experts on chronic condition management from three federal agencies—the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and CMS. After discussing public comments on a proposed list of SNP-specific chronic conditions, the panelists recommended, and CMS

subsequently approved, the following 15 SNP-specific chronic conditions:

1. Chronic alcohol and other drug dependence;

2. Autoimmune disorders limited to:

    - Polyarteritis nodosa,
    - Polymyalgia rheumatica,
    - Polymyositis,
    - Rheumatoid arthritis, and
    - Systemic lupus erythematosus;

3. Cancer, excluding pre-cancer conditions or in-situ status;

4. Cardiovascular disorders limited to:

    - Cardiac arrhythmias,
    - Coronary artery disease,
    - Peripheral vascular disease, and
    - Chronic venous thromboembolic disorder;

5. Chronic heart failure;

6. Dementia;

7. Diabetes mellitus;

8. End-stage liver disease;

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

10. Severe hematologic disorders limited to:

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

11. HIV/AIDS;

12. Chronic lung disorders limited to:

    - Asthma,
    - Chronic bronchitis,
    - Emphysema,

- Pulmonary fibrosis, and
- Pulmonary hypertension;

13. Chronic and disabling mental health conditions limited to:

    - Bipolar disorders,
    - Major depressive disorders,
    - Paranoid disorder,
    - Schizophrenia, and
    - Schizoaffective disorder;

14. Neurologic disorders limited to:

    - Amyotrophic lateral sclerosis (ALS),
    - Epilepsy,
    - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia),
    - Huntington's disease,
    - Multiple sclerosis,
    - Parkinson's disease,
    - Polyneuropathy,
    - Spinal stenosis, and
    - Stroke-related neurologic deficit; and

15. Stroke.

The list of SNP-specific chronic conditions is not intended for purposes other than clarifying eligibility for the C-SNP CCP benefit package. CMS may periodically re-evaluate the fifteen chronic conditions as it gathers evidence on the effectiveness of care coordination through the SNP product, and as health care research demonstrates advancements in chronic condition management.

20.1.3 – Grouping Chronic Conditions

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

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

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

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

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

20.1.3.1 – CMS-Approved Group of Commonly Co-Morbid and Clinically-Linked Conditions

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

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

CMS accepts applications for C-SNPs that focus on the following five multi-condition groupings:

Group 1: Diabetes mellitus and chronic heart failure;

Group 2: Chronic heart failure and cardiovascular disorders;

Group 3: Diabetes mellitus and cardiovascular disorders;

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

Group 5: Stroke and cardiovascular disorders.

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

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

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

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

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

20.2 – Dual Eligible SNPs

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

20.2.1– General *Definitions*

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

20.2.1.1– Eligibility Definitions

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

D-SNPs enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility. Individuals in the following Medicaid eligibility categories may be eligible to enroll in D-SNPs, to the extent permitted in the state Medicaid agency contract (see section 20.2.2 of this chapter):

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

States may vary in determining their eligibility categories; therefore, there may be state-specific differences in the eligibility levels in comparison to those listed here. For specific information regarding Medicaid eligibility categories, refer to: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf.

20.2.1.2 D-SNP Definitions

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

20.2.1.2.1 Definition of a D-SNP

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

Dual eligible special needs plans (D-SNPs) are SNPs that exclusively serve Medicare beneficiaries who are also entitled to Medicaid.

Per 42 CFR 422.2, a D-SNP:

> *(1) Coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services;*

(2) May provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services; and

(3) Has a contract with the state Medicaid agency that meets the minimum requirements in paragraph 42 CFR 422.107(c) (further described in section 20.2.2 of this chapter.)

Additionally, each D-SNP must satisfy one or more of the following criteria for the integration of Medicare and Medicaid benefits:

(1) Meet the additional requirement specified in 42 CFR 422.107(d) in its contract with the state Medicaid agency, or in other words, meet the criteria for a coordination-only D-SNP;

(2) Meet the definition of a highly integrated dual eligible special needs plan (HIDE SNP); or

(3) Meet the definition of a fully integrated dual eligible special needs plan (FIDE SNP).

These concepts and definitions are described in more detail below.

20.2.1.2.2 Definition of FIDE SNP

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

A FIDE SNP is defined in 42 CFR 422.2 as a D-SNP—

- *That provides dually eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable state;*
- *Whose capitated contract with the state Medicaid agency requires coverage of the following elements to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a FIDE SNP in the state, except as approved by CMS under 42 CFR 422.107(g) and (h):*
  - *Primary care and acute care, and for plan year 2025 and subsequent years including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to QMBs;*[1]
  - *Long-term services and supports (LTSS), including coverage of nursing facility services for a period of at least 180 days during the plan year;*
  - *For plan year 2025 and subsequent years, behavioral health services;*
  - *For plan year 2025 and subsequent years, home health services as defined in 42 CFR 440.70; and*
  - *For plan year 2025 and subsequent years, medical supplies, equipment, and appliances, as described in 42 CFR 440.70(b)(3);*
- *That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries;*
- *That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement;*

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[1] *Under 42 CFR 422.107(g) and (h), CMS allows limited carve-outs from the scope of Medicaid LTSS and Medicaid behavioral health services that must be covered by FIDE SNPs and HIDE SNPs. More information on carve-outs can be found in section 20.2.6 of this chapter.*

- *For plan year 2025 and subsequent years, that has exclusively aligned enrollment;*[2] *and*
- *For plan year 2025 and subsequent years, whose capitated contract with the state Medicaid agency covers the entire service area for the D-SNP.*

Beginning in 2025, all FIDE SNPs also qualify as applicable integrated plans, as defined in 42 CFR 422.561 and section 20.2.1.2.5 of this chapter, but not all applicable integrated plans qualify as FIDE SNPs.

20.2.1.2.3 Definition of HIDE SNP

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

A HIDE SNP, as defined in 42 CFR 422.2, is a D-SNP that provides coverage of Medicaid benefits under a capitated contract that meets the following requirements:

- *The capitated contract is between the state Medicaid agency and—*
  - *The MA organization; or*
  - *The MA organization's parent organization, or another entity that is owned and controlled by its parent organization.*
- *The Medicaid capitated contract requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a HIDE SNP in the state, except as approved by CMS under 42 CFR 422.107(g) or (h) (see section 20.2.2.4 of this chapter):*
  - *LTSS, including community-based LTSS and some days of coverage of nursing facility services during the plan year; or*
  - *Behavioral health services.*
- *For plan year 2025 and subsequent years, the capitated contract covers the entire service area for the D-SNP.*

HIDE SNPs may also qualify as applicable integrated plans, as defined in 42 CFR 422.561 and section 20.2.1.2.5 of this chapter, but not all applicable integrated plans are HIDE SNPs.

20.2.1.2.4 Coordination-only D-SNPs

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

If a D-SNP is not a FIDE SNP or a HIDE SNP, it is a coordination-only (CO) D-SNP and is subject to the contracting requirement specified at 42 CFR 422.107(d)(1). CO D-SNPs must have a CMS-approved contract with a state Medicaid agency that stipulates that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the D-SNP notifies, or arranges for another entity or entities to notify, the state Medicaid agency, individuals or entities designated by the state Medicaid agency, or both, of hospital and skilled

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[2] *Aligned enrollment, as defined in 42 CFR 422.2, refers to the enrollment in a D-SNP of full-benefit dually eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract (i.e., Medicaid MCO contract under section 1903(m)(2)(A) of the Act) between (A) the applicable state and (B) the D-SNP's MA organization, the D–SNP's parent organization, or another entity that is owned and controlled by the D–SNP's parent organization. When state policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.*

nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the state Medicaid agency. The state Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a D-SNP authorizes another entity or entities to perform this notification, the D-SNP must retain responsibility for complying with this notification requirement.

There are no federal requirements for FIDE SNPs or HIDE SNPs to comply with the requirement at 42 CFR 422.107(d)(1). However, some states choose to apply similar notifications requirements in their state Medicaid agency contracts for FIDE and/or HIDE SNPs.

For a CO D-SNP that, under the terms of its contract with the state Medicaid agency, only enrolls partial-benefit dually eligible individuals, the data notification requirements at 42 CFR 422.107(d)(1) do not apply if the D-SNP operates under the same parent organization and in the same service area as a D-SNP limited to full-benefit dually eligible enrollees that meets the requirements at 42 CFR 422.107(d)(1) and outlined above in this section. Said another way, partial-benefit-only D-SNPs are not required to meet the notification requirement in 42 CFR 422.107(d)(1) when the MA organization also offers a D-SNP with enrollment limited to full-benefit dually eligible individuals that meets the integration criteria at 42 CFR 422.2 and is in the same state and service area and under the same parent organization.

Table 2: Features of D-SNP Types

Plan Type	***Single entity holds both MA and Medicaid contracts***	***State option to carve out certain Medicaid benefits***	***Integrated materials***	***Exclusively aligned enrollment***	***Applicable integrated plan***	***Medicaid plans cover entire service area of the D-SNP***	***Data notification requirements for enrollee use of hospital or SNF admission***
FIDE SNP	*Required*	*No, except as approved by CMS under 42 CFR 422.107(g) or (h)*	*Required*	*Required in plan year 2025 and later*	*For 2025 and later, all FIDE SNPs are AIPs*	*Required in plan year 2025 and later*	*Not federally required*
HIDE SNP	*Not federally required*	*May carve out LTSS* ***or*** *behavioral health but not both. Any carve-out of services in the category must be approved by CMS under 42 CFR 422.107(g) or (h)*	*Not federally required*	*Not federally required*	*Can qualify as AIPs, but not AIPs by default*	*Required in plan year 2025 and later*	*Not federally required*
CO D-SNP	*Not federally required*	*No requirements on Medicaid benefits provided*	*Not federally required*	*Not federally required*	*Can qualify as AIPs in certain contexts*	*Not federally required*	*Required, except in specific instances for D-SNPs that only enroll partial-benefit dually eligible individuals*

Note: States may apply requirements beyond the federal minimum requirements shown in the table above.

20.2.1.2.5 Applicable Integrated Plan

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

Applicable integrated plans (AIPs) are defined in 42 CFR 422.561 as either of the following arrangements:

- *A FIDE SNP or HIDE SNP and a Medicaid managed care organization where—*
  - *The FIDE SNP or HIDE SNP has exclusively aligned enrollment; and*
  - *The Medicaid managed care organization (as defined in section 1903(m) of the Act and which has a contract under section 1903(m)(2)(A) of the Act) through which such D-SNP, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such D-SNP and such Medicaid managed care organization; or*
- *A D-SNP and affiliated Medicaid managed care plan where—*
  - *The D-SNP, by state policy, has enrollment limited to those beneficiaries enrolled in a Medicaid managed care organization;*
  - *There is a capitated contract between the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization and*
    - *A Medicaid agency, or*
    - *A Medicaid managed care organization that contracts with the Medicaid agency; and*
  - *Through the capitated contract, Medicaid benefits including primary care and acute care, including Medicare cost-sharing without regard to the limitation of that definition to QMBs, and at a minimum, one of the following: home health services as defined in 42 CFR 440.70, medical supplies, equipment, and appliances as described in 42 CFR 440.70(b)(3), or nursing facility services are covered for the enrollees.*

AIPs must offer integrated appeals and grievances at the plan level in accordance with 42 CFR 422.629 through 422.634. More information on integrated appeals and grievances can be found in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans, located here: https://www.cms.gov/files/document/dsnpartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

Beginning in 2025, all FIDE SNPs are AIPs. Currently, most AIPs are FIDE SNPs or HIDE SNPs. CO D-SNPs may qualify as AIPs under certain circumstances. As an example, the following arrangements would be AIPs under current regulations, where both plans include enrollment that is exclusively aligned between the CO D-SNP and the affiliated Medicaid MCO:

- *A CO D-SNP and affiliated Medicaid MCO where the CO D-SNP holds a contract with a separate Medicaid MCO to cover all capitated managed care benefits in the state and the separate Medicaid MCO holds the contract with the state for those benefits; and*
- *A CO D–SNP and affiliated Medicaid MCO where the affiliated Medicaid MCO holds a contract with the state for the capitated Medicaid benefits.*

20.2.2– State Contract Requirements for D-SNPs

(Rev.129, Issued: 08-11-23, Effective: 08- 11- 23; Implementation: 08- 11- 23)

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

The Medicare Advantage Dual Eligible Special Need Plans Application, which is available through HPMS and on the CMS website, provides further information on how and when D-SNPs must submit their state Medicaid agency contracts (SMACs) and related information to CMS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   The SMAC must require a period of performance between the state Medicaid agency and the D-SNP of at least January 1 through December 31 of the year following the due date of the contract. Contracts also may be drafted as multi-year, or "evergreen"

contracts (i.e., continuously valid until a change is made in the contract), as long as the entire calendar year is covered.

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

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

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

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

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

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

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

(1) Under the terms of its SMAC, the D-SNP only enrolls beneficiaries who are not entitled to full medical assistance under a state plan under title XIX of the Act (i.e., partial-benefit dually eligible individuals); and
(2) The D-SNP operates under the same parent organization and in the same service area as a D-SNP limited to beneficiaries with full medical assistance under a state plan under title XIX of the Act (i.e., full-benefit dually eligible individuals) that meets the requirements under 42 CFR 422.107(d)(1).

20.2.3– Relationship to State Medicaid Agencies (42 CFR 422.107(b))
(Rev. 129, Issued: 08-11-23, Effective: 08- 11- 23; Implementation: 08- 11- 23)

Pursuant to section 164(c)(4) of MIPPA, state Medicaid agencies are not required to enter into contracts with MAOs with respect to D-SNPs. In addition to the SMAC, the MAO must still meet all CMS application requirements, including that the organization be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in the state, to have an MA contract and to offer a D-SNP.

20.2.4– Special Cost Sharing Requirements for D-SNPs
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

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

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

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

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

20.2.4.2 - D-SNPs With or Without Medicare Zero-Dollar Cost Sharing
(Rev. 128; Issued:06-30-23; Effective: 06-30-23; Implementation: 06- 30-23)

When MA organizations submit bids for the upcoming contract year, each D-SNP must identify

whether or not the D-SNP has Medicare zero-dollar cost sharing. In HPMS, D-SNPs have the option of one of the following two indicators:

1. Medicare Zero-Dollar Cost Sharing Plan, or

2. Medicare Non-Zero Dollar Cost Sharing Plan.

These two indicators are used in multiple areas within HPMS, and use of the accurate indicator is essential to the proper display of benefits in Medicare Plan Finder.

We strongly encourage states and D-SNPs to finalize D-SNP eligibility criteria in their State Medicaid Agency Contracts well in advance of D-SNP bid submissions. However, if a state changes the Medicaid eligibility criteria it requires the D-SNP to use through the State Medicaid Agency Contract after bid submission and before contract approval, the MA organization will have the ability to change the D-SNP's (or D-SNPs') Medicare Zero-Dollar Cost Sharing D-SNP designation(s) in HPMS.

20.2.4.2.1 Definition of Medicare Zero-Dollar Cost Sharing Dual Eligible Special Needs Plans

(Rev.128; Issued:06-30-23; Effective: 06-30-23; Implementation: 06- 30-23)

A Medicare Zero-Dollar Cost Sharing D-SNP is a D-SNP under which all Medicare Part A and B services are provided with no Medicare cost sharing to all enrollees who remain dually enrolled in both Medicare and Medicaid. This term encompasses the following types of plan designs:

Where cost sharing for enrollees is $0 as part of the plan design (i.e., cost sharing for all Part A and B benefits has been reduced to $0 as part of the supplemental benefits provided by the D-SNP); and

Where there is cost sharing in the plan design, but all individuals who are eligible to enroll in the D-SNP are protected by sections 1848(g)(3)(A) and 1866(a)(1)(A) of the Act from cost sharing, or otherwise qualify for Medicaid coverage of cost sharing (see section 1852(a)(7) of the Act and 42 CFR 422.504(g)(1)(iii) for cost sharing protections afforded non-QMB full-benefit dually eligible individuals).

CMS uses the designation of a Medicare Zero-Dollar Cost Sharing D-SNP to ensure that information provided to beneficiaries is accurate, clear, and consistent with the requirements on MA organizations at 42 CFR 422.111 and 422.2260-422.2267.

For a Medicare Zero-Dollar Cost Sharing D-SNP, information on Medicare Plan Finder on Medicare.gov describe all Part A and B services under the D-SNP, such as inpatient hospital stays and doctor visits, as available at no cost to the enrollee. Plan materials may also describe the D-SNP benefits that way. Such descriptions are accurate – even if the D-SNP plan benefit in the MA organization's bid to CMS includes cost sharing for Medicare Part A and B services – if all individuals who are eligible to enroll in the D-SNP are protected from cost sharing (see number 2 above). An MA plan, including a D-SNP, that has no cost sharing for services under Medicare Part A and B in its plan bid will also have such benefits described as available with no cost sharing, both in plan materials and on Medicare Plan Finder. This information helps dually eligible

enrollees understand what costs they will have when choosing a plan and allows D-SNP materials to clearly show that costs are not a barrier to accessing covered services. When the "Medicare Zero-Dollar Cost Sharing D-SNP" designation is not available, plan materials and Medicare Plan Finder will indicate that cost sharing for Medicare varies depending on the enrollee's category of Medicaid eligibility. Like all MA plans, both Medicare Zero-Dollar Cost Sharing D-SNPs and other D-SNPs can reduce Medicare Part A and B cost sharing as a supplemental benefit. CMS bid review applies the same standards for all D-SNPs.

A D-SNP that includes cost sharing in its plan design may designate itself as a Medicare Zero-Dollar Cost Sharing D-SNP provided that it meets all of the following criteria:

1. The D-SNP plan benefit package limits enrollment, under the terms of its State Medicaid Agency Contract, to dual eligibility categories with Medicare cost sharing protections:

    - QMB Only;
    - QMB Plus;
    - SLMB Plus and;
    - Other Full Benefit Dual Eligibles (FBDE).

    If the D-SNP enrolls members of dual eligibility categories that do not have Medicare cost sharing payable by Medicaid (i.e., SLMB-only, QI, or QDWI), the D-SNP cannot (and must not) be designated as a Medicare Zero-Dollar Cost Sharing D-SNP.

2. The D-SNP provider contracts (1) require that providers accept the D-SNP's payment and any Medicaid payment of Medicare cost sharing (whether paid by the Medicaid agency, the D-SNP itself, or a Medicaid managed care plan) as payment in full and (2) prohibit providers from collecting from a dually eligible enrollee any Medicare cost sharing that is payable under Medicaid (42 CFR 422.504(g)(1)(iii) and 74 FR 1494-1499 (January 12, 2009)).

    Per 42 CFR 422.504(g)(1)(iii), such D-SNP provider contract provisions must also apply to SLMB Plus and FBDE enrollees for whom Medicare cost sharing protections are more limited, if those groups are eligible to enroll in the D-SNP. SLMB Plus and FBDE enrollees cannot be charged Medicare cost sharing above any Medicaid copay applicable to the same service under the Medicaid state plan or a waiver. In the rare instance that a Part A or B service is not covered under the Medicaid state plan or a Medicaid waiver, the cost sharing for a SLMB Plus or FBDE enrollee is the Medicare cost sharing under the MA plan benefit because of the limits in Medicaid coverage. (This is because 42 CFR 422.504(g)(1)(iii) applies when the State is responsible for coverage or payment of the Medicare cost sharing.)

    However, States may elect in their Medicaid State Plan to pay all Medicare cost sharing for all FBDE individuals (including SLMB Plus individuals), even for Medicare services not covered by Medicaid under the State Plan. To comply with § 422.504(g)(1)(iii), Medicare Advantage plans in those states must ensure that their network providers in those states do not charge a SLMB Plus or FBDE enrollee Medicare cost sharing for any Medicare Part A or B service above the Medicaid copay for the same service as covered under the Medicaid State Plan (see 2020 Medicaid Section E of the Coordination of Benefits and Third Party Liability Handbook, Available online at:

https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html). MA organizations can determine if states have made such an election by checking the Medicaid State Plan. We encourage states and D-SNPs to include this information in their State Medicaid Agency Contracts.

Providers can never charge a QMB Only or QMB Plus enrollee Medicare cost sharing for any Medicare Part A or B service above any applicable Medicaid copay per section 1902(p)(3) of the Act.

3. The providers contracted with the D-SNP do not charge Medicaid copays, deductibles, or coinsurance for any Medicaid service that is also a Medicare Part A or B service. If a D-SNP operates in a state that imposes Medicaid copays on dually eligible enrollees for specific services, then the D-SNP must list those Medicaid copays in its plan materials for those services and may not be designated as a Medicare Zero-Dollar Cost Sharing D-SNP, unless:
    - The D-SNP or Medicaid managed care plan responsible for Medicaid payment of Medicare cost sharing does not impose Medicaid copayments for enrollees (i.e., the plan pays the provider the copay in lieu of payment by the dually eligible enrollee); or
    - The state limits its payment of Medicare cost sharing to the Medicaid rate for the service, and the amount the D-SNP pays the provider for the service is equal to or greater than the Medicaid rate, including in any deductible phase of the benefit. (In this circumstance, no Medicaid payment is made so there is no Medicaid copay.)

20.2.4.2.2 Special Considerations for PPO D-SNPs

(Rev.128; Issued:06-30-23; Effective: 06-30-23; Implementation: 06- 30-23)

D-SNP PPOs that that are designated as a Zero-Dollar Cost Share D-SNP may not describe out-of-network services in plan materials as available at "zero cost" because non-contracted providers that are not enrolled in Medicaid may charge the Medicare cost sharing under the plan benefit to non-QMBs. QMB Plus and QMB Only beneficiaries would pay $0; other full-benefit dually eligible individuals would pay the plan benefit cost sharing rate (see sections 1848(g)(3) and 1866(a)(1)(A) of the Act for provisions protecting QMBs regardless whether the MA organization has a contract with the provider that prohibits the collection of cost sharing per 42 CFR 422.504(g)(1)(iii)). For example, an out-of-network service with 30 percent coinsurance under the plan benefit would be described as "$0 or 30 percent." For D-SNPs designated as Zero-Dollar Cost Share, Medicare Plan Finder will continue to show the cost sharing in the plan benefit for out-of-network services, and in-network cost sharing will show $0.

20.2.4.2.3 Medicare Zero-Dollar Cost Sharing D-SNPs and Enrollee Lapse in Medicaid Eligibility

(Rev.128; Issued:06-30-23; Effective: 06-30-23; Implementation: 06- 30-23)

D-SNPs can provide up to six months of deemed continued eligibility for enrollees who have lost, but are expected to regain, Medicaid eligibility, per 42 CFR 422.52(d). The Medicare cost sharing protections for enrollees in a Medicare Zero-Dollar Cost Sharing D-SNP lapse if an enrollee no longer has Medicaid eligibility for any of the dual eligibility categories with cost sharing protections.

During periods when Medicaid eligibility for Medicaid coverage of cost sharing for Medicare Part A and B benefits has lapsed and the individual remains enrolled in the D-SNP, plan providers may collect Medicare cost sharing under the MA plan benefit for the service. Enrollee materials from Medicare Zero-Dollar Cost Sharing D-SNPs, including any required plan notice related to the loss of Medicaid eligibility, must explain that the enrollee may be billed cost sharing for Medicare Part A and Part B benefits if the enrollee loses Medicaid eligibility. This ensures that the materials are accurate as required by 42 CFR 422.111(b)(2)(iii) and 422.2262(a)(1)).

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

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

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

- A home and community-based waiver authorized for a state under section 1115 or subsection (c) or (d) of section 1915 of the Act;
- A Medicaid State Plan Amendment under section 1915(i) of the Act; or
- A Medicaid managed care organization with a contract under section 1903(m) or section 1932 of the Act.

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

- A copy of a state-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the enrollee's name and HCBS eligibility date during a month after June of the previous calendar year;
- A copy of a state-approved HCBS Service Plan that includes the enrollee's name and effective date beginning during a month after June of the previous calendar year;
- A copy of a state-issued prior authorization approval letter for HCBS that includes the enrollee's name and effective date beginning during a month after June of the previous calendar year; or

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

20.2.5 – Additional Requirements for Certain D-SNPs
(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

20.2.5.1– Application of Frailty Adjustment for FIDE SNPs
(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

Section 1853(a)(1)(B)(iv) of the Act gives the Secretary the authority to apply a frailty adjustment payment under the rules for Program of All-Inclusive Care for the Elderly (PACE) payment, for certain FIDE SNPs, to reflect the costs of treating high concentrations of frail individuals. CMS announces its methodology for determining whether a FIDE SNP "has a similar average level of frailty…as the PACE program" in *the annual Announcement of Calendar Year (CY) Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. *Policy changes and changes in the assumptions and methodologies for MA payment and the calculation of the frailty adjustment are discussed each year in the Advance Notice of Methodological Changes for Calendar Year (CY) for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, which is issued at least 60 days before the first Monday in April of the year preceding the calendar year for which the rates and frailty adjustment are applicable. Each year*, we also notify each FIDE SNP of its frailty score and of how it compares to PACE organizations.

*CMS calculates f*railty scores *at the PBP level* using the limitation on activities of daily living (ADL) reported by a plan's enrollees, based on the Medicare Health Outcomes Survey (HOS) *or Health Outcomes Survey-Modified (HOS-M)* from the year previous to the payment year. For example, for payment year 20*24*, CMS will use the 20*23* HOS or HOS-M to determine a frailty score for FIDE SNPs. MA *organization*s that believe they will be sponsoring a FIDE SNP in 20*24* and want to be considered for a frailty payment must participate in the 20*23* HOS or HOS-M to allow for CMS to calculate their frailty score. For more information, please see the annual HPMS memo, "Participation in HOS*/HOS-M* for MA Organizations Planning to Sponsor FIDE SNPs."

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

20.2.6 *– Medicaid Carve-Outs and FIDE SNP and HIDE SNP Status*
(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

CMS determines the integration status for MA organizations offering D-SNPs through our annual SMAC review. As part of the review, CMS assesses the scope of existing or proposed carve-outs against regulatory requirements and determines whether a D-SNP meets the FIDE SNP or HIDE SNP designation. This policy is designed to accommodate differences in state Medicaid policy.

Under 42 CFR 422.107(g) and (h), CMS allows limited carve-outs from the scope of Medicaid LTSS and Medicaid behavioral health services that must be covered by FIDE SNPs and HIDE SNPs.

CMS currently grants FIDE SNP and HIDE SNP status despite limited carve-out of Medicaid LTSS if such carve-outs:

1. *Apply primarily to a minority of the dually eligible LTSS users eligible to enroll in a FIDE SNP or HIDE SNP who use long-term services and supports; or*
2. *Constitute a small part of the total scope of Medicaid LTSS provided to the majority of dually eligible individuals eligible to enroll in a FIDE SNP or HIDE SNP who use Medicaid LTSS.*

CMS did not establish a uniform set of carve-out limits or a numerical limit on carve-outs due to the variation across states.[3]

Examples of permissible LTSS carve-outs for FIDE SNPs and HIDE SNPs that apply to a minority of dually eligible LTSS users may include services specifically limited to individuals with intellectual or developmental disabilities, individuals with traumatic brain injury, or children.

Carve-outs of specific Medicaid LTSS are permissible if the carved-out services would typically only be a small component of the broad array of LTSS provided to the majority of Medicaid LTSS users eligible to enroll in the FIDE SNP or HIDE SNP. CMS would not, however, approve carve-outs for LTSS services for a specific population – for example, individuals with intellectual or developmental disabilities – if enrollment in the FIDE SNP or HIDE SNP was limited to individuals with those disabilities. For example, personal emergency response systems or home modifications may be important supports for participants in a Medicaid home and community-based waiver program, but those specific services would rarely constitute the preponderance of an enrolled dually eligible individual's care plan because most individuals receiving such services also receive other types of in-home supports, such as personal care services. Therefore, approving a carve-out of coverage of personal emergency response systems or home modifications may be permissible under § 422.107(g)(2) where those constitute a small part of the total scope of LTSS provided to the majority of beneficiaries eligible to enroll in the D-SNP. In contrast, CMS would not expect to approve carve-outs of in-home personal care or related support services provided to older adults or people with disabilities even if such services were limited to individuals meeting a nursing home level of care.

CMS defines Medicaid behavioral health carve-outs to be of limited scope if such carve-outs:

1. *Apply primarily to a minority of the dually eligible users of behavioral health services eligible to enroll in the D-SNP who use behavioral health services; or*
2. *Constitute a small part of the total scope of behavioral health services provided to the majority of beneficiaries eligible to enroll in the D-SNP.*

Only a small part of the Medicaid behavioral health services may be carved out to ensure the innovative services that many Medicaid programs provide to individuals with severe and moderate mental illness are covered through the affiliated Medicaid managed care plan (or the D-SNP if it holds the Medicaid managed care contract directly).

Examples of permissible carve-outs that apply to primarily a minority of dually eligible users of such services who are eligible to enroll in the FIDE SNP or HIDE SNP include school-based services for individuals under 21 years of age and court-mandated services where the D-SNP is not limited to individuals under 21 years of age.

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[3] *For further discussion, see 87 FR 27757*

Examples of permissible carve-outs that constitute a small part of the total scope of Medicaid behavioral health services include inpatient psychiatric facilities and other residential services, specifically payment of Medicare cost-sharing or coverage of days not covered by Medicare; substance abuse treatment, such as payment of Medicare cost-sharing or coverage of services not covered by Medicare; services provided by a Federal Qualified Health Center or Rural Health Clinic; and Medicaid-covered prescription drugs for treatment of behavioral health conditions.[4]

20.2.7 State D-SNP-only Contracts

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

20.2.7.1 Limiting Certain MA Contracts to D-SNPs

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

Through the SMAC, a state can require MA organizations to (a) apply for and seek CMS approval of MA contracts that only include one or more D-SNPs with exclusively aligned enrollment within a state and (b) require those D-SNPs to utilize certain integrated materials and notices for enrollees. CMS will facilitate such requirements in accordance with the procedures and requirements at 42 CFR 422.107(e). CMS will approve D-SNP-only contracts when a state, through the SMAC, requires exclusively alignment enrollment, requires the D–SNPs to request MA contracts that only include one or more state-specific D–SNPs, and requires the D-SNP to use (and the D-SNP uses) certain minimum integrated member materials. However, implementation of such D-SNP-only contracts requires prior notification and administrative activities to begin well in advance of the applicable contract year.

20.2.7.2 State Notification to CMS

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

Implementation of a D-SNP-only contract and development of integrated plan materials generally requires administrative steps that cannot be completed between reviewing the contract (after bid submission) and the start of the plan year. CMS will begin good faith work following receipt of a letter from the state Medicaid agency indicating intent to include the requirements for a D-SNP-only contract and use of integrated materials in a future contract year and collaborate with CMS on implementation. To begin the process to establish state D-SNP-only contracts under 42 CFR 422.107(e)(2), CMS requests the respective state Medicaid agency submit a letter to CMS regarding its intention to pursue the further integration opportunities available under 42 CFR 422.107(e)(1) by August of two years prior (e.g., August 2023 in anticipation of implementation in plan year 2025) to enable the MA organization and CMS to start the necessary steps. More information on this process can be found in previous guidance at the following link: https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf

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[4] *As discussed in the CMS-4185-F rule, CMS had historically determined D-SNPs to be FIDE or HIDE SNPs when they meet the necessary requirements but included limited carve-outs of certain services from the Medicaid coverage provided by the Medicaid managed care plan. The CMS HPMS memorandum entitled, "Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans," January 17, 2020 (retrieved from: https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf) discussed the policy later finalized at 422 CFR 422.107(g) and (h) and discussed in section 20.2.6 of this chapter. The requirements at 422 CFR 422.107(g) and (h) and discussed in section 20.2.6 of this chapter supersede the January 17, 2020 HPMS memorandum.*

20.2.7.3 Integrated Materials
(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

To meet the requirements of 42 CFR 422.107(e)(1)(ii), the SMAC must require the D-SNP(s) to use required materials that integrate Medicare and Medicaid content, including at a minimum the Summary of Benefits, Formulary, and combined Provider and Pharmacy Directory. The state may require use of additional integrated materials. Integrated materials must meet Medicare and Medicaid managed care requirements consistent with applicable regulations in 42 CFR 422, 423, and 438. CMS coordinates with states that choose to require, through their SMACs, that a D-SNP with exclusively aligned enrollment integrate its Medicare and Medicaid member materials to ensure these integrated materials comply with regulatory requirements.

20.2.7.4 Joint State/CMS Oversight
(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

To enhance coordination between states, D-SNPs, and CMS, states that establish D-SNP-only contracts have the opportunity to collaborate with CMS on oversight activities through access to the Health Plan Management System (HPMS) and coordination on program audits. The state must request access to HPMS and comply with applicable rules and policies related to such access (e.g., agree to protect the proprietary nature of information to which the state Medicaid agency may not otherwise have direct access). More information on these activities can be found at 42 CFR 422.107(e)(3) and in the CY 2023 MA and Part D final rule published on May 9, 2022 (87 FR 27773).

20.2.8– Benefit Flexibility for Certain D-SNPs
(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

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

20.2.8.1 – Benefit Flexibility Eligibility Requirements
(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

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

- *Be a specialized MA plan for dual-eligible special needs individuals described in section 1859(b)(6)(B)(ii) of the Act.*
- *Be operational in the upcoming CY and have operated the entire previous CY.*

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

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

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

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

- *Be part of a contract with a current three-star (or higher) overall rating on the Medicare Plan Finder website. Please note: If the D-SNP is part of a contract that does not have sufficient enrollment to generate a star rating, CMS will base the ratings on the most recent SNP plan-level Healthcare Effectiveness Data and Information Set (HEDIS) measures. The plan must receive 75 percent or greater on at least five of the following measures:*

  - *Controlling Blood Pressure;*
  - *Appropriate Monitoring of Patients Taking Long-Term Medications;*
  - *Board-Certified Physicians (Geriatricians), Care for Older Adults - Medication Review;*
  - *Care for Older Adults - Functional Status Assessment;*
  - *Care for Older Adults - Pain Screening; and*
  - *Medication Reconciliation Post-Discharge.*

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

20.2.8.2 – Characteristics and Categories of Flexible Supplemental Benefits

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

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

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

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

medication management.

- ***Must*** *be provided to the enrollee at zero cost.*
- ***Must not*** *be duplicative of Medicaid, including the State Medicaid or local benefits for enrollees who are eligible to receive identical Medicaid services.*
- ***Must not*** *be duplicative of Medicare, including Medicare supplemental benefits (described in chapter 4 of the MMCM).*
- ***Must*** *be uniformly offered and available to all enrollees.*

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

Table 3: Flexible Supplemental Benefits for Consideration

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

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

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

20.2.8.3 – Benefit Flexibility Approval Process

(Rev. 130; Issued: 01-12-24; Effective: 01-12-24; Implementation: 01-12-24)

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

1. *Submit notification to CMS of their intent to offer flexible supplemental benefits;*
2. *Receive a CMS determination that the D-SNP is eligible;*
3. *Submit a bid that incorporates the flexible supplemental benefits the D-SNP intends to offer; and*
4. *Receive CMS approval of the D-SNP's bid.*

In order for a D-SNP to offer the flexible supplemental benefits, CMS must first determine the D-

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

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

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

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

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

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

Eligible D-SNPs that choose to offer flexible supplemental benefits shall include the proposed benefit(s) as a part of their PBPs during bid submission. The plan must attest, at the time of bid submission, that the flexible supplemental benefit(s) described in the PBP does not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid Plan, Medicare Part A or B, or through the local jurisdiction in which they reside. CMS will review the flexible supplemental benefit(s) submitted with the PBPs and determine whether these benefits comply with the requirements.

20.3 – Institutional SNPs

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

20.3.8– General

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

I-SNPs are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility. A complete list of acceptable types of institutions can be found in the Medicare Advantage Enrollment and Disenrollment Guidance at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html.

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

CMS may allow an I-SNP that operates either single or multiple facilities to establish a county-based service area as long as it has at least one long-term care facility that can accept enrollment and is accessible to the county residents. As with all MA plans, CMS will monitor the plan's marketing/enrollment practices and long-term care facility contracts to confirm that there is no discriminatory impact.

20.3.9– Institutional Equivalent SNPs

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

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

1. A determination of institutional LOC that is based on the use of a state assessment tool. The assessment tool used for persons living in the community must be the same as that used for individuals residing in an institution. In states and territories without a specific tool, I-SNPs must use the same LOC determination methodology used in the respective state or territory in which the I-SNP is authorized to enroll eligible individuals.

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

20.3.10 – Change of Residence Requirement for I-SNPs

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

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

20.3.11 – I-SNPs Serving Long-Term Care Facility Residents

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

I-SNPs that serve residents of LTC facilities must own, operate, or have a contractual arrangement

with the LTC facility. The LTC facility must adhere to the I-SNP's approved MOC. CMS requires that the contract between the I-SNP and the LTC facility include the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

specified.

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

30 – Application, Approval, and Service Area Expansion Requirements
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

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

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

The SNP application contains a list of questions and attestations requiring a "yes" or "no" response and requires the applicant to upload documentation in support of responses to the questions and attestations. This is generally similar to the format of the MA application. The timeline for submitting the SNP application is the same as the MA application timeline. All SNP applications must be submitted electronically through the Health Plan Management System (HPMS) to CMS by the SNP application due date. The MA application and the SNP application for the current contract year are available at http://www.cms.hhs.gov/MedicareAdvantageApps/. The SNP application is located in appendix I of the MA application.

30.2 – Model of Care Approval
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

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

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

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

Table 4: Overview of MOC Review and Cure Processes

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

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

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

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

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

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

30.4 – Service Area Expansion

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

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

Table 5: SNP SAE Scenarios

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

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

40 – Enrollment Requirements

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

40.1 – General

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

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

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

SNPs that choose whether to opt in to the Online Enrollment Center (OEC) are held to the same accountability as other MAOs. MAOs must accept enrollments through the OEC. Additional guidance on enrollment processes is available in the Medicare Advantage Enrollment and

Disenrollment Guidance. Refer to section 40.2.1 of this chapter and the Medicare Advantage Enrollment and Disenrollment Guidance for more information about C-SNP eligibility verification processes. The Medicare Advantage Enrollment and Disenrollment Guidance also includes information about special election periods (SEPs) for dual-eligible enrollees or enrollees who lose their dual eligibility.

40.2 – Verification of Eligibility

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

40.2.1 – Verification of Eligibility for C-SNPs

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

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

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

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

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

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

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

- The MAO conducts a post-enrollment confirmation of each enrollee's information and eligibility using medical information (medical history, current signs and/or symptoms, diagnostic testing, and current medications) provided by the enrollee's existing provider or a plan provider.

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

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

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

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

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

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

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

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

When an individual elects to enroll in an I-SNP before she/he has received at least 90 days of institutional LOC, the I-SNP may use a number of sources of information to show that the

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

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

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

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

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

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

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

40.3 – Waiver to Enroll Individuals with ESRD

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

Pursuant to section 1851(a)(3)(B) of the Act, MAOs are not permitted to enroll individuals with ESRD. However, a SNP may enroll individuals with ESRD if it has obtained a waiver from CMS to be open for enrollment to individuals with ESRD under 42 CFR 422.52(c). MAOs should request this waiver as part of the SNP application. The ESRD waiver is available to all types of SNPs. CMS's decision to grant an ESRD waiver is conditional upon the SNP arranging access to services specifically targeted to individuals living with ESRD (e.g., nephrologists, hemodialysis centers, and renal transplant centers).

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

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

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

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

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

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

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

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

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

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

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

40.4 – Continued Eligibility When an Enrollee Loses Special Needs Status

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

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

During the period of deemed continued eligibility for a D-SNP specifically, the D-SNP must

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

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

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

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

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

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

40.6 – Open Enrollment Period for Institutionalized Individuals

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

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

50 – Renewal Options and Crosswalks

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

50.1 – General

(Rev. 127, Issued: 06-02-23, Effective: 01-01-23, Implementation: 01-01-23)

The guidance in this section specifically applies to SNP renewal options and crosswalks as codified at 42 CFR 422.530.[1] The regulation at 42 CFR 422.530 was adopted in 2021 to codify longstanding guidance with some modifications. Tables 6 through 8 below provides an overview of the SNP crosswalk policy. For general crosswalk guidance for all MA plans (as well as MA

[1] See also the final rules at 86 FR 5864, 5963 - 5969 (Jan. 19, 2021) (available online here: https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-00538.pdf) and 87 FR 27704, 27743 – 27768 (May 9, 0222) (available online here: https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf) for discussion of § 422.530.

special needs plans), please refer to the Bid Submission User Manual, located under the Plan Bids tab in HPMS.

50.2 – D-SNP Non-Renewals for lack of a State Medicaid Agency Contract

(Rev. 127, Issued: 06-02-23, Effective: 01-01-23, Implementation: 01-01-23)

All MAOs that offer D-SNPs must have contracts with State Medicaid Agencies in the states in which they operate per section 1859(f)(3)(D) of the Act and 42 CFR 422.107. In the event that an MAO is not able to secure such a contract (or subcontract) with the State Medicaid Agency(ies) for one or more of its D-SNPs, the MAO must terminate those D-SNPs in accordance with 42 CFR 422.506 through 422.512. Enrollees in those plans will be disenrolled from their D-SNP and may elect to receive Part A and Part B benefits under original Medicare or another MA plan into which they wish to enroll. Enrollees who are dual-eligible have a SEP at 42 CFR 422.62(b)(1) available when an MA plan, (including a D-SNP), is terminating. In addition, enrollees who are dually eligible individuals have a SEP at 42 CFR 423.28(c)(4) that may be used once per quarter for the first 3 quarters of the calendar year by dually eligible individual or who are LIS eligible to changing MA-PD plans including D-SNPs. In the event of a D-SNP non-renewal, the D-SNP enrollees who do not make an enrollment request will be enrolled by default into original Medicare and automatically enrolled in a benchmark stand-alone PDP after the termination of the D-SNP. For more information about SEPs and enrollment periods available to dually eligible individuals, refer to Chapter 2 of the MMCO, which is also posted as the MA Enrollment and Disenrollment Guidance here: https://www.cms.gov/medicare/eligibility-and-enrollment/medicaremangcareeligenrol.

50.3 – SNP Crosswalks

(Rev. 127, Issued: 06-02-23, Effective: 01-01-23, Implementation: 01-01-23)

A crosswalk is the movement of enrollees from one plan (or plan benefit package (PBP)) to another plan (or PBP) under a contract between the MAO and CMS. To crosswalk enrollee from one PBP to another is to change the enrollment from the first PBP to the second. Except as specified in 42 CFR 422.530(c)(2), (3), and (4)(ii), MAOs may not crosswalk enrollees from one contract to another contract. MAOs may not crosswalk enrollees from one SNP type to a different SNP type.

In addition, MAOs must comply with renewal and nonrenewal rules in 42 CFR §§ 422.505 and 422.506 in order to complete plan or PBP crosswalks. Please refer to 42 CFR § 422.530 for the standard crosswalk rules applicable to all MA plans, including all SNPs. Please also refer to the annual End-of-Year Enrollment and Payment Systems Processing Information memo released each year for details related to the Medicare Advantage and Prescription Drug (MARx) System Transaction Processing and Rollover and Terminating Plan MARx Transaction Processing instructions. The tables below outline the crosswalk scenarios for D-SNPs, C-SNPs, and I-SNPs.

Table 6: C-SNP Crosswalk Scenarios

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	HPMS Plan Crosswalk
Renewing C-SNP with one chronic condition that transitions eligible enrollees into another C-SNP with a grouping that contains that same chronic condition. Non-renewing C-SNP with one chronic condition that transitions eligible enrollees into another C-SNP with a grouping that contains the same chronic condition. Non-renewing C-SNP with a grouping that is transitioning eligible enrollees into a different C-SNP if the new grouping contains at least one condition that the prior plan contained.	42 CFR 422.530(b)(2)(i)(A) 42 CFR 422.530(b)(2)(i)(B) 42 CFR 422.530(b)(2)(i)(C)	No	No. Except as provided by § 422.530(c), crosswalks are prohibited between different contracts or different plan types (for example, HMO to PPO or from one type of SNP to a different type of SNP). Several types of exceptions are addressed elsewhere in Tables 6 through 8.	During Bid Submission window, select Plan Crosswalk Designation: Consolidated Plan Renewal
Renewing C-SNP with a grouping of multiple conditions that is transitioning eligible enrollees into another C-SNP with one of the chronic conditions from that grouping.	42 CFR 422.530(c)(5)	Yes	No. This is not one of the exceptions permitting a crosswalk across contracts.	During Bid Submission window, select Consolidated Renewal Plan

Table 7: D-SNP Crosswalk Scenarios

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	Guidelines	HPMS Plan Crosswalk
Renewing D-SNP with a multi-state service area that reduces its service area and moves enrollees who are no longer in the service area of the renewing D-SNP to one or more renewing D-SNPs (for which the enrollees are eligible) offered under the same parent organization.	42 CFR 422.530(c)(3)	Yes	Yes	Movement is permitted if the enrollees are eligible for the receiving D-SNPs and CMS determines the crosswalk is necessary to accommodate changes to the contracts between the state and D-SNP under 42 CFR 422.107.	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 2 – Renewing D-SNP with service area change, includes RPPO to LPPO
A D-SNP in a RPPO that non-renews to create state-specific local PPOs in its place to accommodate state contacting efforts in the service area and moves enrollees who are no longer in the service area to one or more renewing D-SNPs offered under the same parent organization.	42 CFR 422.530(c)(3)	Yes	Yes	Movement is permitted if the enrollees are eligible for the receiving D-SNPs and CMS determines the crosswalk is necessary to accommodate changes to the contracts between the state and D-SNP under 42 CFR 422.107.	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 2 – Renewing D-SNP with service area change, includes RPPO to LPPO
Renewing D-SNP has another new or renewing D-SNP and the two D-SNPs are offered to different populations, and moves enrollees who are no longer eligible for their current D-SNP into the	42 CFR 422.530(c)(4)(i)	Yes	No	Movement is permitted if the enrollees meet the eligibility criteria for the new or renewing D-SNP and CMS determines it is in the best interest of the enrollees to move to the new or renewing D-SNP in order to promote access and continuity of	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 3 – Change in D-SNP populations

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	Guidelines	HPMS Plan Crosswalk
other new or renewing D-SNP offered by the same MAO.				care for enrollees relative to the absence of a crosswalk exception.	
MAO creates a new D-SNP-only MA contract when required by a state as described in 42 CFR 422.107(e), eligible enrollees may be moved from the existing D-SNP (that is non-renewing or having its eligible population newly restricted by a state to achieve exclusively aligned enrollment) to a D-SNP offered under the D-SNP-only contract.	42 CFR 422.530(c)(4)(ii)	Yes	Yes	The new D-SNP-only contract is approved and permitted by CMS under § 422.107(e) and movement must be to the same plan type operated by the same parent organization.	During Crosswalk Exception Submission window, select Crosswalk Exception Request Type 9 – MA-PD with a D-SNP transition to D-SNP only contract

Table 8: I-SNP Crosswalk Scenarios

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	HPMS Plan Crosswalk
Renewing Institutional SNP that transitions enrollees to an Institutional/Institutional Equivalent SNP	42 CFR 422.530(b)(2)(ii)(A)	No	No	During Bid Submission window, select Consolidated Renewal Plan
Renewing Institutional Equivalent SNP that transitions enrollees to an Institutional/ Institutional	42 CFR 422.530(b)(2)(ii)(B)	No	No	During Bid Submission window, select

Activity	Regulatory Authority	Requires Crosswalk Exception	Allows Movement across Contracts	HPMS Plan Crosswalk
Equivalent SNP				Consolidated Renewal Plan
Renewing Institutional/ Institutional Equivalent SNP that transitions eligible enrollees to an Institutional SNP	42 CFR 422.530(b)(2)(ii)(C)	No	No	During Bid Submission window, select Consolidated Renewal Plan
Renewing Institutional/ Institutional Equivalent SNP that transitions eligible enrollees to an Institutional Equivalent SNP	42 CFR 422.530(b)(2)(ii)(D)	No	No	During Bid Submission window, select Consolidated Renewal Plan
Nonrenewing Institutional/Institutional Equivalent SNP that transitions eligible enrollees to another Institutional/Institutional Equivalent SNP	42 CFR 422.530(b)(2)(ii)(E)	No	No	During Bid Submission window, select Consolidated Renewal Plan

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

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

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

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

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

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

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

- Supplemental health benefits specific to the needs of the unique SNP population;
- Specialized provider networks (e.g., physicians, home health, hospitals, etc.) specific to the unique SNP population; and
- Appropriate enrollee cost sharing structured around the unique SNP population's health conditions and co-morbidities for all Medicare-covered and supplemental benefits.

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

- No or lower cost sharing;
- Longer benefit coverage periods for inpatient services;
- Longer benefit coverage periods for specialty medical services;

- Parity (equity) between medical and mental health benefits and services;

- Additional preventive health benefits (e.g., dental screening, vision screening, hearing screening, age-appropriate cancer screening, risk-based cardiac screening);

- Social services (e.g., connection to community resources for economic assistance) and transportation services; and

- Wellness programs to prevent the progression of chronic conditions.

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

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

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

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

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

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

For more information on CMS's meaningful difference requirements for SNPs, please refer to the annual "Announcement," located at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

80 – Quality Improvement
(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

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

90 – SNP Health Risk Assessment Screening Requirement
(Rev. 129; Issued: 08-11-23; Effective: 01-01-24; Implementation: 01-01-24)

90.1 – General
(Rev. 129; Issued: 08-11-23; Effective: 01-01-24; Implementation: 01-01-24)

Regulations at 42 CFR 422.101(f)(1)(i)[2] require that all MA SNP health risk assessments (HRAs) must include at least one question from a list of screening instruments specified by CMS in sub-regulatory guidance on each of three domains (housing stability, food security, and access to transportation) beginning in contract year (CY) 2024. This requirement helps to better identify the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence and enable SNPs to take these risk factors into account in enrollee individualized care plans. This section provides the list of CMS-specified screening instruments available for SNPs to meet the requirement.

90.2 - Instruments for Screening for Housing Stability, Food Security, and Access to Transportation
(Rev. 129; Issued: 08-11-23; Effective: 01-01-24; Implementation: 01-01-24)

SNPs can meet the requirement at 42 CFR 422.101(f)(1)(i) in one of two ways:

1. **Use a state-required screening instrument that includes questions on the required domains.**

   As discussed in the CY 2023 MA and Part D Final Rule (87 FR 27734), SNPs can use state-required Medicaid screening instruments that include questions on housing stability, food security, and access to transportation to satisfy the HRA content requirement in 42 CFR 422.101(f)(1)(i). By allowing SNPs to use the questions in state-required screening instruments, we aim to prevent duplication of screening efforts. For the purposes of this requirement, SNPs that are required by a state to use a certain screening instrument in the same contract year may use that state-required instrument to meet this requirement. For example, a SNP required by a state to use an assessment instrument in CY 2024 that includes questions on these domains could use that instrument to meet the requirement at 42 CFR 422.101(f)(1)(i) for CY 2024.

   In addition, CMS recognizes that SNPs operating in a particular state that are not subject to state assessment requirements (e.g., chronic condition special needs plans [C-SNPs] and institutional special needs plans [I-SNPs] are not required to have contracts with states) may wish to use an assessment instrument a state requires for dual eligible special needs plans (D-SNPs) to satisfy the requirement at 42 CFR 422.101(f)(1)(i) if that instrument includes questions in the three required domains. C-SNPs and I-SNPs may use such a state-required assessment instrument to meet this requirement as long as the state requires that instrument for D-SNPs in the same state in the same contract year, as outlined above. For example, a C-SNP operating in a state that requires D-SNPs to use a certain assessment instrument in CY 2025 may use that state-specified instrument to meet the 42 CFR 422.101(f)(1)(i) requirement to include questions in the specified domains in CY 2025 so long as that instrument includes the questions in the three required domains. Such SNPs may use

[2] https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf

questions on the three required domains from a state-required assessment as part of their HRA without using the entire state-required assessment (i.e., adding questions on the three domains to the SNP's own existing HRA instrument).

Finally, SNPs may use state-required screening instruments for plans whose service areas include a state that requires a particular state-specific screening instrument. For example, a SNP plan benefit package whose service area encompasses the Kansas City metro area could include counties in both Missouri and Kansas. In this example, if Missouri required a certain state-specific screening instrument and Kansas did not, the plan may use the Missouri state-required screening instrument for all enrollees in that service area, including those who reside in Kansas.

While many states that require screening for these three domains are using validated screening instruments, some state-required screening instruments may be state-specific and not meet the standards described below (e.g. not a validated, health information technology (IT)-encoded instrument). This could create a challenge for data standardization and interoperability. However, CMS believes the need for flexibility outweighs this potential challenge but may revisit this position in the future. We encourage SNPs to reach out to the states in which they operate with any questions about state-specific screening requirements.

2. Select questions on the required domains from validated, health information technology (IT)-encoded screening instruments.

Alternatively, if not using a state-required screening instrument, SNPs may select questions from other validated, health IT-encoded screening instruments. Table 7 in section 90.1.2 specifies CMS's list of social needs screening instruments from which SNPs must select questions on the three required domains to meet the requirement at 42 CFR 422.101(f)(1)(i) if the SNP does not use a state-required screening instrument that includes questions on the required topics (see Table 7 below).

CMS aimed to include validated, widely used screening instruments and considered the availability of screening instruments, including whether they are proprietary or require a fee. The list in Table 7 includes a number of screening instruments that are non-proprietary and/or available at no cost. For those screening instruments that are proprietary, SNPs are responsible for securing the necessary licenses to use the intellectual property of entities that own these instruments and the questions as formulated in them.

In addition, use of the questions from a specific screening instrument specified by CMS must be consistent with the instructions for the screening instrument for the SNP's use of the question(s) on housing, food security, and access to transportation to satisfy the SNP's obligations under 42 CFR 422.101(f)(1)(i). CMS's review of the questions on the screening instruments specified in Table 7 has taken into account instructions and permissible variations. Therefore, when the developer of a screening instrument allows users to make certain adaptations (e.g., translation into other languages), SNPs should make changes consistent with the screening instrument's specifications or consult with the relevant screening instrument developer to determine what adaptations may be acceptable and

whether such adaptations require permission from the instrument developer. SNPs may also want to consult with the instrument developer to understand how any adaptations to the instrument questions might affect their validity. 42 CFR 422.2267(a)(2) requires that MA organizations must translate required materials, including HRAs, into any non-English language that is the primary language of at least five percent of the individuals in a plan benefit package service area. In addition, beginning for 2024, fully integrated and highly integrated D-SNPs (and applicable integrated plans as defined in 42 CFR 422.561) must translate required materials into the language(s) required by the Medicaid translation standard specified in the capitated Medicaid managed care contract held by the D-SNP or its affiliated Medicaid managed care plan.

In selecting the screening instruments from which a SNP may select questions to comply with 42 CFR 422.101(f)(1)(i), CMS applied the following criteria:[3]

- **Screening instruments that are validated, widely used, and available**. CMS determined that the screening instruments the stakeholder-led Gravity Project has identified as appropriate to screen for the each of the three required domains meet this standard. The Gravity Project is a national public collaborative that convenes stakeholders through an open and transparent collaborative process to develop and test consensus-based standards to facilitate social determinants of health (SDOH) data capture.[4]

- **Screening instruments that maximize opportunities for SNPs to collect and analyze standardized, quantifiable, and actionable data.** CMS determined that, in order to meet this standard, questions and responses in screening instruments should be mapped to health IT vocabulary standards (i.e., have available LOINC® coding terminology).

As described in the CY 2023 MA and Part D Final Rule, CMS considered the extensive work various stakeholders have already done to research and validate screening instruments in developing the above criteria. The above criteria align with the data elements established as part of the United States Core Data for Interoperability, Version 2, in which LOINC® is identified as an applicable vocabulary standard for SDOH assessments.[5] By identifying validated screening instruments that use available health IT coding terminology as acceptable sources for the questions required by 42 CFR 422.101(f)(1)(i), CMS aims to encourage greater standardization of social needs screening data and facilitate interoperable exchange of such data.

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[3] Furthermore, Table 7 in section 90.1.2 also incorporates screening instruments included in the specification for the National Committee for Quality Assurance's (NCQA) Social Need Screening and Intervention" measure in HEDIS Volume 2: Technical Specifications for Health Plans, 705-717.

[4] The Gravity Project convenes subject matter experts to evaluate and vote on the validity and appropriateness of available assessment instruments to screen for various domains. For the purposes of this requirement, we have combined Gravity's three housing-related domains (housing instability, homelessness, and inadequate housing) into one topic ("housing stability").

[5] See the final USCDI v2 document: https://www.healthit.gov/isa/sites/isa/files/2021-07/USCDI-Version-2-July-2021-Final.pdf.

The screening instruments in Table 7 meet the above criteria at the time CMS updated this section. However, the social needs screening field is evolving quickly, and screening instruments that currently do not meet the criteria outlined above may meet those criteria in the future (e.g., new LOINC® coding terminology may be created for a screening instrument for which it was previously not available).

Therefore, in addition to the list of screening instruments specified in Table 7, SNPs can use questions on the three required domains from screening instruments included in the Gravity Project's lists linked below of screening instruments by domain, which can be found in the National Library of Medicine Value Set Authority Center (VSAC).[6] The Gravity Project compiles these lists to include screening instruments with available LOINC® coding that its members have identified as appropriate to screen for each domain, and will update them if and when new screening instruments meet these standards. CMS has determined the assessment instruments on these lists meet the criteria described above and are permissible for a SNP to draw from for the required questions on housing stability, food security, and access to transportation. Please note that VSAC users must create an account and be logged in to access the links below.

- **Food Security:** VSAC Food Insecurity Screening Assessments
- **Housing Stability:** VSAC Homelessness Screening Assessments; VSAC Housing Instability Screening Assessments; VSAC Inadequate Housing Screening Assessments
- **Access to Transportation:** VSAC Transportation Insecurity Screening Assessments

Currently, the screening instruments included in the VSAC are also listed in Table 7. In the future, the VSAC lists may expand to include additional instruments that meet the above criteria. CMS will review the VSAC resources linked above to ensure that questions on the three domains are acceptable under 42 CFR 422.101(f)(1)(i). SNPs may use questions from assessment instruments included in this value set as of July 2023.

CMS Post-Acute Care (PAC) Assessment Instruments
Table 7 includes several CMS PAC assessment instruments that include a question on access to transportation that is almost identical to a transportation question included in the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment instrument, but has a small modification to the response choices.
These assessment instruments have been thoroughly tested, have associated LOINC coding to collect standardized data, and are already in use by providers. SNPs may use them to meet the requirement for including one or more questions on access to transportation in their HRAs. More details about the CMS PAC assessment instruments can be found in the CMS Data Element Library.

90.2.1 - Additional Considerations

(Rev. 129; Issued: 08-11-23; Effective: 01-01-24; Implementation: 01-01-24)

[6] VSAC is a repository for clinical coding vocabularies that define clinical concepts to support interoperable health information exchange, and is provided by the National Library of Medicine in collaboration with the Office of the National Coordinator for Health Information Technology and CMS.

Equity & Accessibility

CMS encourages SNPs to consider equity issues in selecting screening instruments and questions, including the questions required by 42 CFR 422.101(f)(1)(i). In particular, SNPs should consider whether the instrument has been validated for racial and ethnic minority populations that the SNP serves and whether the instrument can be translated into languages that are commonly spoken by the SNP's enrollees. In addition, SNPs should consider whether they can provide the questions in accessible formats using auxiliary aids and services as required by section 1557 of the Affordable Care Act and implementing regulations at 45 CFR Part 92. These regulations require plans to provide appropriate auxiliary aids and services, including interpreters and information in alternate formats, to individuals with impaired sensory, manual, or speaking skills where necessary to afford such persons an equal opportunity to benefit from the service.

Questions from Multiple Assessment Instruments

SNPs are not required to adopt any of these screening instruments wholesale. SNPs must adopt one or more questions related to each of the required three domains specified in 42 CFR 422.101(f)(1)(i) in their HRAs. SNPs do not need to select questions on the three required domains from just one assessment instrument. For example, a SNP may choose one question from a particular screening instrument on food security, and a question on housing stability from another screening instrument. This also applies to state-required assessment instruments. For example, if a SNP uses a state-required assessment that includes questions about housing stability and food security, but does not include any questions about access to transportation, the SNP must still include a question on access to transportation in its HRA and therefore must select one or more questions on access to transportation from an assessment instrument specified by CMS in this guidance.

Assessment Instruments with Multiple Questions on the Same Domain

There may be instances where an instrument includes multiple questions in the required domains. For example, an assessment instrument may include a question about housing instability as well as a question about quality of housing—both of which pertain to the required housing stability domain. If an instrument includes more than one question for a domain and a SNP elects to screen for that domain using that instrument, CMS strongly encourages the SNP adopt all of the questions for that domain in their health risk assessment. Validated assessment instruments with multiple questions on the same domain have been validated as a panel of questions and may be less accurate at screening an enrollee for a particular need when only one question from that panel is used. However, a SNP can comply with 42 CFR 422.101(f)(1)(i) even if the plan does not use the full suite of questions on a domain from a particular screening instrument.

90.3 – List of Social Needs Screening Instruments

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Table 7: Social Needs Screening Instruments (Version 1.0)

Note: In selecting a question in one of the required domains from the screening instruments specified here, SNPs should use the most recent version of the screening instrument(s).

SNP Social Needs Screening Instruments			
	Housing Stability	**Food Security**	**Access to Transportation**
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	X	X	X
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	X	X	X
Health Leads Screening Panel®	X	X	X
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE]®	X	X	X
We Care Survey	X	X	
WellRx Questionnaire	X	X	X
Hunger Vital Sign™ (HVS)		X	
U.S. Household Food Security (SNPs can select questions from the 18-, 10-, or 6-item surveys)		X	
Comprehensive Universal Behavior Screen (CUBS)			X
PROMIS®			X
CMS Post-Acute Care (PAC) Assessment Instruments: • **Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF- PAI)** • **Long-Term Care Hospitals Continuity Assessment Record and Evaluation Data Set (LCDS)** • **Home Health Agencies Outcome and Assessment Information Set (OASIS)**			X