UPMC LIFE CHANGING MEDICINE

Medicare Managed Care Manual
Chapter 16B – Special Needs Plans SNP

January, 2017

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MA Chapter 16B Special Needs Plans

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Why Is This Training Important To You?

- CMS holds the Plan accountable to the guidance in MA Chapter 16B – Special Needs Plans.
- CMS performs audits to determine if we are following their regulations.
- We are required to follow the guidelines as listed in the chapters unless otherwise stated by CMS.
- Your department is at least partially responsible for executing these regulations so we are in compliance with CMS.

Resources

- CMS: http://www.cms.gov
- Medicare Compliance SharePoint Site: http://spis.upmc.com/healthplan/MedicareCompliance/default.aspx
- Policies and Procedures SharePoint Site: http://spis.upmc.com/healthplan/Compliance/Policy/default.aspx
- Medicare Compliance Department: medicarecompliance@upmc.edu
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10.2 - Statutory and Regulatory History

- The Medicare Modernization Act of 2003 (MMA) established a Medicare Advantage Coordinated Care Plan (MA CCP) that was specifically designed to provide care to individuals with special needs.
  - In the MMA, Congress identified "*Special Needs Individuals*" as:
    - Institutionalized individuals;
    - Dual eligibles; and/or,
    - Individuals with severe or disabling chronic conditions as specified by CMS.
- The first SNP plans were effective on January 1, 2006.
- 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.**

10.2 - Statutory and Regulatory History

Section 3205 of the Affordable Care Act (ACA) amended sections 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).
- Authorize CMS to apply a frailty adjustment payment for Fully Integrated Dual Eligible (FIDE) SNPs.
  - Frailty scores are calculated using the limitation on activities of daily living (ADL) reported by a plan's enrollees, based on the Medicare Health Outcomes Survey (HOS) from the year previous to the payment year.
- Improve risk adjustment for special needs individuals with chronic health conditions.

10.3 Requirements and Payment Procedures

- SNPs are expected to follow existing Medicare Advantage (MA) program rules, 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.

- 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.

40 – SNP Enrollment Requirements

- SNPs may only enroll individuals who meet the Plan's specific eligibility criteria and enrollment requirements.

- SNPs must include elements on the enrollment request that correspond to the special needs criteria of the particular SNP.

- Plans must accept enrollments through the Online Enrollment Center (OEC), SNPs may choose whether to opt in to the OEC. The OEC can be found on the *Medicare.gov website*.
  - UPMC *for Life* Dual **does** accept OEC enrollments,
  - UPMC *for Life* Options **does not** accept OEC enrollments due to the specific plan criteria.

20.2 Dual Eligible SNPs
D-SNPs

- D-SNPs enroll individuals who are entitled to both Medicare and Medical Assistance from a State Plan under Medicaid.

- These Medicaid eligibility categories encompass all categories of Medicaid eligibility including:
  - Full Medicaid (only);
  - Qualified Medicare Beneficiary without other Medicaid (QMB only);
  - QMB Plus;
  - Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only);
  - SLMB Plus;
  - Qualifying Individual (QI); and
  - Qualified disabled and Working Individual (QDWI).

- UPMC is able to verify full dual status via the PA state eligibility system called POSNET and using the full versus partial dual crosswalk.

20.2.2 – State Contract Requirements for D-SNPs

- All D-SNPs are required to have an executed contract with applicable State Medicaid Agencies.
- CMS requires the D-SNP to submit a State Medicaid Agency Contract (SMAC) for review by July 1 every year.
- A D-SNP with an "evergreen contract" (multi-year – continuously valid until a change is made in the contract- as long as the entire calendar year is covered***) is still required to submit*** its contract to CMS by July 1 and must include:
  - A letter from the State Medicaid Agency stating that it intends to continue contracting with the Plan for the upcoming calendar year.

40.2.2 – Verification of Eligibility for D-SNPs

- 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:
  - 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, POSNet.

40.4 – Continued Eligibility When an Enrollee Loses Special Needs Status

- A SNP enrollee may become ineligible for the plan following his/her enrollment due to the loss of his/her special needs status.

- SNPs must continue to provide care for at least one full calendar month for a member who no longer has special needs status if:
  - The individual can reasonably be expected to again meet SNP eligibility criteria within a 6-month period.

- The SNP may choose any length of time from one month to 6 months for deeming continued eligibility as long as the Plan:
  - Provides appropriate care,
  - Applies the criteria consistently among all member, and
  - Fully informs members of its policy.

40.4 – Continued Eligibility When an Enrollee Loses Special Needs Status *continued*

- *During the period of deemed continued eligibility for a D-SNP, the D-SNP:*
  - Must continue to provide all MA plan-covered Medicare benefits,
  - Is not responsible for continued coverage of Medicaid benefits that are included under the applicable Medicaid State Plan, nor
  - Is it responsible for Medicare premiums or cost sharing for which the state would be liable had the enrollee not lost his/her Medicaid eligibility.

40.4 – Continued Eligibility When an Enrollee Loses Special Needs Status *continued*

- *This is what UPMC calls a "Grace Period".*
  - 2016 - Members who lost their Medical Assistance were given a 90-120 day grace period.
  - For 2017, the Grace Period will be extended to 180 days due to an update in the State Contract.

- If a member is unable to regain their Medical Assistance coverage, they are *disenrolled.*
  - To try to prevent members from being disenrolled:
    - Member Services performs outreach calls to encourage members to contact their County Assistance Office (CAO).
    - A letter is also sent informing members to contact their CAO and be redetermined back into Medical Assistance.
    - Text messages are sent to members with a UPMC sponsored "Tracfone".

UPMC 's Grace Period- UPMC *for Life* Dual

- UPMC *for Life* Dual members will be provided, in 2017 with a 180 day grace period, when they lose their Medical Assistance coverage.
- During the grace period, UPMC *for Life* Dual members are encouraged to contact their County Assistance Office (CAO) to regain full Medical Assistance.
- UPMC *for Life* dual members who are unable to regain full Medical Assistance coverage will be disenrolled after the grace period ends.
- Once the member is disenrolled, they will return to Original Medicare unless they enroll in another Medicare Advantage Plan.

UPMC 's Grace Period- UPMC *for Life* Dual

- While in the grace period:
  - Members will not be responsible for copayments or coinsurance for covered services, except for Part D prescription drug copayments.
  - Members will remain responsible for the Part B premium at all times, unless this amount is paid on their behalf.
  - If a member receives a balance bill from a provider, they are encouraged to call Member Services, as members are not responsible for balance bills.
    - UPMC *for Life* Dual providers are not allowed to balance bill our members.

(Once members are in the Grace Period, the out-of-pocket accumulates, the Part B deductible is not taken. Part B drugs are also paid at 100% once the member is in the Grace Period. If a member is trying to get a Part B drug during the time they lost their full Medical Assistance and when they are in the Grace Period, the claim will need to be adjusted to pay at 100%).

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

- ***CMS provides a Special Election Period (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.
  - SNPs must send out the appropriate notice explaining the disenrollment to the beneficiary.

- *More information can be found in Chapter 2, Medicare Managed Care Manual*
  - *The SEP begins when* the period of deemed continued eligibility starts and ends when the beneficiary makes an enrollment request or three months after the expiration of the period of deemed continued eligibility.

20.2.4 – Special Cost Sharing Requirements for D-SNPs
20.2.4.1 - General

- Plans offering D-SNPs must enforce limits on out-of-pocket costs (OOPCs) for dual-eligible individuals.

- *D-SNPs cannot impose cost sharing requirements on specified dual-eligible individuals (Full Medicaid individuals, QMBs, or any other population designated by the state)* that would exceed the amounts permitted under the State Medicaid Plan if the individual were not enrolled in the D-SNP.
  - This category includes
    - QMBs and QMB+,
    - Two categories of dual-eligible that have all Medicare Parts A and B cost sharing paid by Medicaid, and may include
    - Other dual-eligible enrollees that the state holds harmless for Part A, Part B, or Part D cost sharing.

20.2.4 – Special Cost Sharing Requirements for D-SNPs
20.2.4.1 – General *continued*

- D-SNPs must establish a Maximum out-of-pocket (MOOP) limit even though the state Medicaid program usually pays those costs on the member's behalf.

- CMS requires D-SNPs to establish annual MOOP limits because a member's eligibility for Medicaid may change during the year, leaving the member liable for cost sharing.

- For purposes of tracking out-of-pocket spending relative to the MOOP limit, the Plan must count only the actual OOP expenditures for which the member is responsible and not the cost sharing amounts for services the Plan has established in its PBP.
  - For those D-SNP members who are not responsible for paying the Medicare Parts A and B cost sharing, the MOOP limit will rarely be reached.
    - *Plans must still track OOP spending for these members*.

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

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.

20.3 – Institutional SNPs

- **I-SNPs:** SNPs that restrict enrollment to Medicare Advantage eligible individuals who for 90 days or longer, have had or are expected to need the level of services provided in a/an:
  - Long-term care (LTC) skilled nursing facility (SNF),
  - LTC nursing facility (NF),
  - SNF/NF,
  - Intermediate care facility for individuals with intellectual disabilities(ICF/IDD), or
  - Inpatient psychiatric facility.

20.3.2 – Institutional Equivalent SNPs

- A SNP that enrolls Medicare Advantage eligible individuals living in the community, but requiring an institutional level of care, *must meet both* the following eligibility requirements:
  - Determination of institutional level of care (LOC) must be based on the use of a State assessment tool, (which must be the same tool used for individuals residing in an institution) and
  - UPMC must arrange to have the LOC assessment administered by an independent, impartial party with the professional knowledge to accurately identify institutional LOC.
    - UPMC *for Life* Options (I-SNP) uses the Area Agency on Aging (AAA) to perform the level of care assessments for our I-SNP members.

20.3.3 – Change of Residence Requirement for I-SNPs

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

- If this situation arises, Medical Management can be contacted for assistance.

UPMC's I-SNP: UPMC *for Life* Options

- UPMC *for Life* Options is an I-SNP that serves members living in an institution as well as living at home/in the community.

- UPMC *for Life* Options contracts with the following facilities:
  - Canterbury
  - Seneca
  - Heritage
  - Manor Care Shadyside

- For members living in the Community UPMC *for Life* Options utilizes Staying-at-Home and the Area Agency on Aging to assist members and connects them with Community Resources.

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

- When an I-SNP opts to enroll a beneficiary before he/she has received at least 90 days of institutional LOC, the I-SNP may use a number of sources to verify their eligibility:
  - State LOC assessment tool
  - Current Minimum Data Set (MDS) data; or
  - Letter from the nursing facility on their letterhead stating that the nursing facility expects the beneficiary to require a stay in excess of 90 days.

- *I-SNPs* that enroll individuals *living in the community and requiring an institutional LOC* must submit to CMS:
  - State LOC assessment tool; and
  - The entity performing the LOC assessments

- *This information is submitted to CMS via HPMS as part of the SNP Application*.

40.6 - Open Enrollment Period for Institutionalized Individuals

- 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.

- *More information is found in Chapter 2, Medicare Managed Care Manual.*
  - The OEPI is continuous for eligible individuals.
  - For purposes of enrollment under the OEPI election period:
    - *An institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution.*
  - The OEPI ends two months after the month the individual moves out of the institution.
  - Since UPMC *for Life* Options services members living in an institution as well as in the community, they do not have to be disenrolled.

30.2 - Model of Care Approval

- Every SNP must have an NCQA-approved Model of Care (MOC).

- The MOC:
  - Provides the basic framework under which the SNP will meet the needs of its members.
  - Is a vital quality improvement tool and integral component for ensuring that the unique needs of each member are identified and addressed through the Plan's Care Management practices.
  - Provides the foundation for promoting SNP quality, care management, and care coordination processes.
  - Scoring criteria and SNP MOC elements are located in Chapter 5 of the Medicare Managed Care Manual (MMCM)

30.2 - Model of Care Approval *continued*

- 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.
  - 85% to 100% 3-year approval
  - 75% to 84% 2-year approval
  - 70% to 74% 1-year 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 (MOC) Re-Approval and Application Submissions

CMS has clarified and provided examples of when a Plan must submit a MOC for a SNP.

- UPMC must submit a MOC if one of the following scenarios applies:
  - UPMC seeks to offer a new SNP;
  - UPMCs 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

- Plans are not required to submit a new Model of Care (MOC) when requesting a service area expansion for a SNP

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6o - Marketing

- SNPs must market to all individuals eligible to enroll.
  - Examples
    - 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 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. Found in Chapter 3, Medicare Managed Care Manual – found on the CMS.gov website

Questions