DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: January 17, 2020

TO: Dual Eligible Special Needs Plans

FROM: Sharon Donovan
Director, Program Alignment Group

SUBJECT: Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)

On October 7, 2019, CMS issued an HPMS memorandum summarizing new requirements and providing guidance to Dual Eligible Special Needs Plans (D-SNPs) on the contract and operational changes needed for each type of D-SNP beginning for Contract Year (CY) 2021.[1] Since that time, the CMS Medicare-Medicaid Coordination Office has participated in a number of calls with states and MA organizations and identified several issues for additional clarification, including: (1) distinctions between fully integrated D-SNPs (FIDE SNPs) and highly integrated (HIDE SNPs); (2) permissibility of carve-outs of behavioral health services and long term services and supports (LTSS) for FIDE SNPs and HIDE SNPs; (3) alignment of D-SNP and companion Medicaid plan service areas; and (4) compliance with integration requirements for D-SNPs that only enroll partial-benefit dually eligible individuals. We address each below.

Distinctions between FIDE SNPs and HIDE SNPs

Some states require some or all D-SNPs to provide their full-benefit dually eligible enrollees with capitated Medicaid benefits under a Medicaid managed care contract – particularly for behavioral health services and LTSS. Such D-SNPs may meet the criteria for qualification as FIDE SNPs or HIDE SNPs, depending on the scope of Medicaid services and the contractual arrangements used by the D-SNP and its parent organization. Appendix 1 provides more detail on the similarities and differences between FIDE SNPs and HIDE SNPs with respect to the specific integration requirements each must meet.

Carve-outs of Long-term Services and Supports and Behavioral Health Services Permissible for D-SNPs Seeking Designation as FIDE SNPs or HIDE SNPs

States vary considerably in the specific Medicaid LTSS and behavioral health services they cover and the ways those services are delivered to full-benefit dually eligible individuals. Those services can be delivered through capitated contracts with Medicaid plans that are affiliated with D-SNPs, or directly through capitated contracts with D-SNPs. However, in either case, states

[1] See https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf.

may exclude (that is, carve out) some specific LTSS or behavioral health services from those capitated contracts. As we articulated in the preamble of our April 2019 final rule,[2] a carve-out by the state of a minimal scope of LTSS or behavioral health services, consistent with state policy, would not preclude CMS from designating a plan as a FIDE SNP or a HIDE SNP as defined at 42 CFR 422.2. Variability in how Medicaid LTSS and behavioral health services are delivered makes it difficult to establish black-and-white national standards regarding specific carve-outs that are permissible for a D-SNP to be designated by CMS as a FIDE SNP or HIDE SNP.

We provide below additional guidance clarifying how CMS intends to assess LTSS and behavioral health services coverage for purposes of determining FIDE SNP and HIDE SNP status under 42 CFR 422.2. In drafting this guidance, we took into account the following guiding principles:

- Ensuring compliance with the statute and regulations;
- Consistency with past CMS interpretation of statute and regulation;
- Providing predictability for states and health plans;
- Accommodating variation in how states elect to cover Medicaid services in their capitated contracts with Medicaid managed care plans; and
- Providing flexibility in how states carve out LTSS and behavioral health services that:
    - Apply primarily to a minority of the of the full-benefit dually eligible recipients of LTSS and behavioral health services eligible to enroll in the D-SNP; and
    - Constitute a small part of the totality of Medicaid-covered LTSS and behavioral health services provided to the majority of full-benefit dually eligible recipients of such services who are eligible to enroll in the D-SNP.

CMS will make a determination about the permissibility of a carve-out based on the specific circumstances, eligible population, and services covered by a D-SNP. In determining whether a carve-out is minimal, the complete context of the overall covered population and covered services is important and must be taken into account to ensure that the standard is met. However, our guidance provides various examples of potentially permissible carve-outs, as there seem to be some situations where it is clear that the carve-out is a minimal one in the vast majority of situations.

FIDE SNP Coverage of LTSS

Section 1853(a)(1)(B)(iv) of the Social Security Act establishes that FIDE SNPs must cover long-term care under a capitated contract with the state. In our regulations at 42 CFR 422.2, we implemented the long-term care coverage requirement for a FIDE SNP such that either the D-SNP or an affiliated Medicaid managed care organization (MCO) offered by the same legal entity as the D-SNP must cover **both** institutional and community-based LTSS under a

[2] See 84 FR 15706, retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

capitated contract with the state. As explained in the April 2019 final rule preamble,[3] community-based LTSS are essential to the coverage model offered by a FIDE SNP because such services are long-term care services. Additionally, as part of their LTSS coverage, FIDE SNPs must include coverage of Medicaid nursing facility services of at least 180 days during the plan year. In codifying this revised definition of "FIDE SNP," we also incorporated previous subregulatory policy[4] that long-term care service carve-outs or exclusions are permissible only if a D-SNP can demonstrate that it is at risk for substantially all Medicaid services under the Medicaid capitated rate. Therefore, if a D-SNP provides coverage of both community-based LTSS and institutional LTSS (which must be at least the required 180 days per year of nursing facility benefits), a carve-out by the state of other LTSS of minimal scope is permissible.

We reviewed the breadth of LTSS covered by current FIDE SNPs to better understand the characteristics of LTSS carve-outs and provide a framework for determining whether an LTSS carve-out is of such minimal scope such that a D-SNP qualifies for FIDE SNP status. An LTSS carve-out would be of minimal scope if such carved out services are consistent with 1 **or** 2 below. The examples provided are not exhaustive and are based on our experience and review of existing FIDE SNP carve-outs to identify situations where the carve-out is sufficiently minimal.

1. **Apply primarily to a minority of the full-benefit dually eligible LTSS users eligible to enroll in the FIDE SNP.** Services that are primarily used by distinct subsets of the Medicaid population that constitute a small minority of the full-benefit dually eligible LTSS users eligible for the plan could be carved out without a significant impact on the requirement that a FIDE SNP, or an affiliated Medicaid MCO, be at risk for substantially all Medicaid benefits under the state's Medicaid capitation rate.[5] Examples of permissible LTSS carve-outs for FIDE SNPs may include services specifically limited to:

    - Individuals with intellectual or developmental disabilities
    - Individuals with serious mental illness
    - Individuals with traumatic brain injury
    - Children

[3] See 84 FR 15708, retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

[4] This policy was first established in the April 2, 2012, issuance of the ''Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,'' retrieved from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents, and later memorialized in Chapter 16b of the Medicare Managed Care Manual, retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

[5] Whether a carve out is sufficiently limited in scope to be minimal (for purposes of determining if a D-SNP is a FIDE SNP) depends on the population eligible for the D-SNP, as established in the state Medicaid agency contract. Our examples assume that the D-SNP is available to all full-benefit dually eligible beneficiaries. However, if eligibility for a particular D-SNP is limited to one of the eligibility categories described in our examples of permissible carve-outs, we would not make a determination of FIDE SNP status when LTSS targeted to that population are carved out.

2. **Constitute a small part of the total scope of LTSS provided to the majority of full-benefit dually eligible individuals eligible to enroll in the FIDE SNP who receive LTSS.** Capitated Medicaid coverage includes nursing facility services (including some days for which Medicaid coverage is primary). Exclusions of specific LTSS would be permissible if the carved out services would typically only be a small component of the broad array of LTSS provided to the majority of LTSS users eligible to enroll in the FIDE SNP. For example, personal emergency response systems or home modifications may be important supports for participants in a Medicaid home and community-based waiver program. However, those specific services would rarely constitute the preponderance of a participant's care plan because most people receiving such services also receive other types of in-home supports, such as personal care services.

   In contrast, we would not expect to approve carve-outs of in-home personal care or related services provided to older adults or people with disabilities even if such services were limited to individuals meeting a nursing home level of care.

States or D-SNPs with LTSS carve-outs can email MMCO_DSNPOperations@cms.hhs.gov for guidance on whether such service carve-outs would be permissible for D-SNPs seeking a FIDE SNP designation.

FIDE SNP Coverage of Behavioral Health Services

As discussed in the April 2019 final rule preamble,[6] FIDE SNPs are not required to cover behavioral health services in cases where the state decides to carve out behavioral health services from the capitated rate. State contracts with D-SNPs seeking FIDE SNP designation should indicate, for all behavioral health services under the state plan, which services are covered under the capitated rate and which are carved out.

HIDE SNP Coverage of LTSS

Consistent with 42 CFR 422.2, a D-SNP may meet the criteria for designation as a HIDE SNP if it covers, consistent with state policy, **either** (1) LTSS **or** (2) Medicaid behavioral health services, under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP.

As discussed in the April 2019 final rule preamble, the breadth of LTSS coverage under a HIDE SNP does not have to be as broad as the coverage provided by a FIDE SNP.[7] For example,

[6] See 84 FR 15706, retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

[7] See 84 FR 15798, retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

HIDE SNPs are not required to provide at least 180 days of nursing facility coverage during the plan year.[8]

A D-SNP may obtain designation as a HIDE SNP when it covers LTSS in the community and institutional settings – under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP. To obtain the HIDE SNP designation, such capitated coverage must include **both** of the following:

1. Community-based LTSS (with any carve-outs consistent with those permissible for FIDE SNPs described in the "FIDE SNP Coverage of LTSS" section of this memorandum); **and**

2. Institutional LTSS (coverage of nursing facility services must include some days for which Medicaid coverage is primary but, in contrast to a FIDE SNP, may be less than 180 days each year).

HIDE SNP Coverage of Behavioral Health Services

Instead of – or in addition to – obtaining a HIDE SNP designation by covering LTSS as described in the "HIDE SNP Coverage of LTSS" section of this memorandum, a D-SNP may obtain such a designation if it, or a Medicaid plan affiliated with the D-SNP by virtue of being owned and controlled by the same parent organization, covers Medicaid behavioral health services. A behavioral health services carve-out would be of minimal scope if such carved out services are consistent with 1 **or** 2 below. The examples provided are not exhaustive and are based on our experience and review of existing FIDE SNP carve-outs to identify situations where the carve-out is sufficiently minimal.

1. **Apply primarily to a minority of the full-benefit dually eligible users of behavioral health services eligible to enroll in the HIDE SNP.** Examples of permissible Medicaid behavioral health service carve outs of Medicaid for HIDE SNPs[9] may include:

    - School-based services for individuals under age 21
    - Court-mandated services

[8] In addition, a D-SNP may qualify as a HIDE SNP under 42 CFR 422.2 by virtue of its affiliation with a Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP), both of which cover less comprehensive sets of services than Medicaid MCOs. Based on the PIHP and PAHP definitions at 42 CFR 438.2, the scope of PIHP services can be limited to inpatient or institutional services, while the scope of PAHP services specifically excludes inpatient and institutional services.

[9] Whether a carve-out is sufficiently limited in scope to be minimal (for purposes of determining if the D-SNP is a HIDE SNP) depends on the population eligible for the D-SNP, as established in the state Medicaid agency contract. Our examples assume that the D-SNP is available to all full-benefit dually eligible individuals.

2. **Constitute a small part of the total scope of behavioral health services for which Medicaid is generally the primary payer.**[10] Examples of permissible carve-outs may include:

    - Inpatient psychiatric facilities and other residential services (payment of Medicare cost sharing or coverage of days not covered by Medicare)
    - Substance abuse treatment (payment of Medicare cost sharing or coverage of services not covered by Medicare)
    - Services provided by a Federally Qualified Health Center or Rural Health Center
    - Medicaid-covered prescription drugs.

States or D-SNPs with behavioral health service carve-outs can email MMCO_DSNPOperations@cms.hhs.gov for guidance on whether such service carve-outs would be permissible for D-SNPs seeking a HIDE SNP designation.

Alignment of D-SNP and Companion Medicaid Plan Service Areas

As we have indicated in the CY 2016 and CY 2019 Call Letters,[11] CMS remains committed to providing administrative flexibility that facilitates efforts by state Medicaid agencies and MA organizations to use D-SNPs to integrate coverage of Medicare and Medicaid benefits, including in the areas of integrated beneficiary communications, D-SNP models of care, and enrollment processes. HIDE SNPs and FIDE SNPs can achieve greater integration for their enrollees when their D-SNP service areas are maximally aligned with the service areas of companion Medicaid plans affiliated with their organizations. Such alignment of service areas allows not only for better integration of Medicare and Medicaid benefits for enrollees, but also provides opportunities for HIDE and FIDE SNPs to take advantage of administrative flexibilities to better coordinate member communications materials, models of care, and – beginning 2021, or earlier if required by the state in its contract with the D-SNP under 42 CFR 422.107, and when enrollment is exclusively aligned – to unify Medicare and Medicaid appeals and grievance procedures.

To further integration for full-benefit dually eligible individuals in D-SNPs, we encourage MA organizations offering D-SNPs to consider ways in which alignment of D-SNP service areas relative to those of affiliated entities offering capitated Medicaid benefits would be beneficial. Such alignment could also simplify compliance with the three Medicare-Medicaid integration criteria specified in the definition of a D-SNP at 42 CFR 422.2. MA organizations can use the bid process, as well as available plan crosswalk and crosswalk exceptions procedures described in more detail in Chapter 16B of the Medicare Managed Care Manual, to further align D-SNP service areas with the service areas of companion Medicaid plans.

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[10] If the scope of Medicaid LTSS or behavioral health services under a Medicaid state plan is so limited that Medicare is the primary payer for all such services, and the state or territory capitates D-SNPs for coverage of all Medicaid services for which full-benefit dually eligible individuals are eligible, then such D-SNPs can be designated as HIDE SNPs.

[11] See https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

However, D-SNPs can meet the requirements to be designated as a HIDE SNP or FIDE SNP under 42 CFR 422.2 even if their service area within a particular state does not fully align with the service area of the companion Medicaid plan (or plans) affiliated with their organization. In other words, a D-SNP can still obtain a HIDE SNP or FIDE SNP designation if its D-SNP service area is smaller or larger than that of its companion Medicaid plan(s).

Compliance with Integration Requirements for D-SNPs that Only Enroll Partial-Benefit Dually Eligible Individuals

Some MA organizations have separate D-SNP plan benefit packages (PBPs) for partial-benefit dually eligible individuals (QMB only or QMBs, SLMB, QI, etc.) and for full-benefit dually eligible individuals (QMB+, SLMB+, FBDEs).[12] Providing a separate PBP for full-benefit dually eligible individuals enables MA organizations to more clearly explain and coordinate the Medicaid benefits that those enrollees are entitled to receive. In addition, for D-SNPs that qualify as HIDE SNPs or FIDE SNPs, limiting enrollment only to full-benefit dually eligible individuals is a prerequisite to qualifying as an "applicable integrated plan," defined at 42 CFR 422.561, that can unify Medicare and Medicaid appeals and grievance processes under 42 CFR 422.629 – 634.

The three criteria for the integration of Medicare and Medicaid benefits are codified in the definition of a D-SNP at 42 CFR 422.2. However, under 42 CFR 422.2, there is no explicit pathway through which a partial duals-only D-SNP could meaningfully meet one of the three integration standards. No plan members are eligible for Medicaid services that a HIDE SNP or FIDE SNP must cover, and there are no full-benefit dually eligible enrollees that the plan could identify for notification of hospital and skilled nursing facility (SNF) admissions (and no Medicaid services to coordinate post notification) under 42 CFR 422.107(d).

A D-SNP that only enrolls partial-benefit dually eligible beneficiaries could meet the letter of our new integration requirements if its state Medicaid agency contract (SMAC) includes a provision for notification of hospital and SNF admissions for the state's chosen population of high-risk full-benefit dually eligible individuals, even though there are no members of the D-SNP for whom the notification would actually apply (because none are FBDEs). However, requiring inclusion of such a notification provision in the SMAC would not benefit the D-SNP's enrollees and seems to impose an unnecessary administrative burden.

In lieu of requiring inclusion of such notifications in the SMAC for a partial-benefit-only D-SNP, for purposes of initial implementation of integration requirements in the 2021 plan year, CMS will consider a partial-benefit-only D-SNP as meeting the integration requirements at 42 CFR 422.107(d) if the MA organization offering the partial-benefit-only D-SNP also offers, in the same state and under the same contract with CMS, a D-SNP limited only to full-benefit dually eligible individuals that meets the integration criteria in the definition of a D-SNP at 42 CFR 422.2. We are considering future rulemaking on this topic.

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[12] See https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf the following for definitions of the categories of dually eligible individuals.

Additional Resources

Our October 7, 2019 memorandum included a list of CMS and Integrated Care Resource Center (ICRC) resources for additional information for D-SNPs. Below are additional resources that have been made available since that time:

- **State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs.** (https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d) provides examples of ways that states can share Medicaid enrollment information with D-SNPs to meet the integration requirement to coordinate members' Medicare and Medicaid services.

- **Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for State Medicaid Agency Contracts with D-SNPs for Contract Year 2021.** (https://www.medicaid.gov/federal-policy-guidance/downloads/cib111419-2.pdf), a CMCS Informational Bulletin that summarizes the requirements of the April 2019 final rule and highlights important information that states need to ensure that D-SNPs in their market meet the new integration and unified appeals and grievance requirements beginning in 2021.

- **Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans** (https://www.integratedcareresourcecenter.com/resource/sample-language-state- medicaid-agency-contracts-dual-eligible-special- needs-plans) provides sample language that states can use in their D-SNP State Medicaid Agency Contracts that is designed to comply with CMS requirements.

- **MMCO D-SNP Webpage (**https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs) includes information, guidance, and resources related to the implementation of D-SNP integration and unified appeals and grievance requirements developed pursuant to the Bipartisan Budget Act of 2018.

More Information

For any questions about the contents of this memorandum, D-SNPs should contact their account manager.

Appendix 1: Attributes of FIDE SNPs and HIDE SNPs

Attributes of FIDE SNPs and HIDE SNPs		
	FIDE SNP	**HIDE SNP**
Must have a contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the Act.	Yes	No
May provide coverage of Medicaid services to full-benefit dually eligible enrollees via a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP).	No	Yes
Must provide coverage of applicable Medicaid benefits to full-benefit dually eligible enrollees through the same entity that contracts with CMS to operate as an MA plan.	Yes	No. The state Medicaid contract may be with: (1) the MAO offering the D-SNP; (2) the MAO's parent organization; or (3) another entity owned and controlled by the MAO's parent organization.
Must have a capitated contract with the state Medicaid agency to provide coverage of LTSS to full-benefit dually eligible enrollees, consistent with state policy.	Yes	No, if the capitated contract otherwise covers behavioral health services.
Must have a capitated contract with the state Medicaid agency to provide coverage of behavioral health services to full-benefit dually eligible enrollees, consistent with state policy.	No. Complete carve-out of behavioral health coverage by the state Medicaid agency is permitted.[13]	No, if the capitated contract otherwise covers LTSS.

[13] See 84 FR 15706, retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

Attributes of FIDE SNPs and HIDE SNPs		
	FIDE SNP	**HIDE SNP**
Must have a capitated contract with the state Medicaid agency to provide coverage of a minimum of 180 days of nursing facility services to full-benefit dually eligible enrollees during the plan year.	Yes	No
May qualify for a frailty adjustment to their Medicare payment.	Yes – if specific criteria for frailty adjustment are met.	No