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		APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals		

Description of the Issue or Question	Comments & Recommendation(s) from Source	CMS Decision *(Accept, Accept with Modification, Reject, Clarify)*
The draft application instructions explicitly state that Existing SNPs that require re-approval under the NCQA SNP Approval process should only submit the Model of Care written narrative and Model of Care Matrix Upload Document and will not be required to submit any other portion of the MA application or SNP proposal, unless specifically noted.	We believe that the State Medicaid Agency contract submission requirements for renewal dual-eligible SNPs, which we understand are existing dual-eligible SNPs that are not expanding their service areas, should be addressed in a manner similar to the MOC requirements. Specifically, we recommend that the instructions be revised to indicate that these dual-eligible SNPs will be required to meet only the submission requirements for state contracts and will not be required to submit any other portions of the MA	**Accept:** CMS revised the instructions in the *Part C – Medicare Advantage and 1876 Cost Plan Expansion Application: APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals* to state that "existing dual eligible SNPs will need to a submit signed and executed State Medicaid Agency Contract in HPMS without submitting any other portions of the SNP proposal unless the existing D-SNP is changing its D-SNP subtype or applying for a Service Area Expansion."
This section of the draft instructions for the SNP proposal states that all 2013 Applicants seeking to offer a dual-eligible SNP must have a contract with the State Medicaid Agency(ies) from each State in which the SNP operates and notes that the requirement applies to "all initial, service area expansion and renewal dual-eligible SNP applicants."	For clarity, we recommend that the instructions here, as well as in section 2.4 as discussed above, be revised to explicitly indicate that such SNPs will be required to submit only the sections of the SNP proposal relating to state contracts (e.g., Section 6. D-SNP State Medicaid Agency(ies) Contract(s), etc.,) in addition to any other specifically designated portions of the SNP proposal (e.g., the Model of Care requirements, as needed), and will not be required to complete other portions of the MA Application or SNP proposal.	**Accept**: As stated above, CMS revised the instructions in the ***Part C – Medicare Advantage and 1876 Cost Plan Expansion Application: APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals*** **to state that "existing dual eligible SNPs will need to a submit signed and executed State Medicaid Agency Contract in HPMS without submitting any other portions of the SNP proposal unless the existing D-SNP is changing its D-SNP subtype or applying for a Service Area Expansion."**
We appreciate that the CMS CY 2012 Final Call Letter indicates that the agency is developing operational policy that will reflect both State budgetary and contracting timelines and align the dual-eligible SNP contract submission deadline with the MA contracting process.	As CMS moves forward with this coordination effort, we continue to urge the agency to retain a deadline for submission of contracts with State Medicaid agencies that is no earlier than the current deadline of July 1.	**Clarification:** The deadline for submitting a signed and executed State Medicaid Agency Contract remains the same as last year. The current deadline for submitting the State Medicaid Agency contracts is July 1, 2012.

The draft application indicates that all 2013 applicants seeking to offer a new severe or disabling chronic condition SNP or expand the service area of an existing SNP of this type must exclusively serve individuals confirmed to have one of the CMS-approved chronic conditions.We note that in the "2008 Special Needs Plan Chronic Condition Panel Final Report" the panelists "acknowledged that the present recommendations should be re-evaluated at the Secretary's discretion as Center for Medicare and Medicaid Services gathers evidence of the effectiveness of care coordination through the SNP product, and healthcare research demonstrates advancements in chronic condition management."	We are not aware that such a re-evaluation has taken place and encourage the agency to conduct a re-evaluation consistent with the panel's report, including considering additions to the CMS-approved list of chronic conditions, for example, the addition of combinations of conditions that reflect common patterns of comorbities.	**Clarification:** SNPs will need to continue to use the 15 current chronic conditions. However, CMS will consider moving forward with a re-evaluation of the 15 chronic conditions to include additional conditions or a combination of conditions that reflect common patterns of co-morbidities.
The revised definition of a zero-cost-share D-SNP indicates that such a SNP has a State Medicaid agency contract to limit enrollment to QMBs only and QMB+, "the two categories of dual eligible beneficiaries who are not financially responsible for cost sharing for Medicare Parts A or B." However, we understand that the categories of dual-eligible individuals for which a State may cover A/B cost sharing can vary by State and include categories in addition to QMBs and QMB+ (e.g., SLMB+ and Full Benefit Dual Eligible (FBDE) individuals).	To encompass the full spectrum of relevant eligibility categories, we recommend that CMS revise the definition to specify that a Zero Cost Share D-SNP also could cover other dual eligible beneficiaries that the State holds harmless for Part A and Part B cost sharing. The revision would be consistent with the version of the definition that was included in the 2012 Part C application.	**Reject with Clarification:** In order to be a Medicare zero-cost-share D-SNP, a SNP must only enroll QMB or QMB+ enrollees. These are the only categories of beneficiaries for which States are statutorily required to pay all Medicare Parts A&B cost-sharing. We do not include other categories of beneficiaries in this D-SNP subtype, because States may choose to change their cost-sharing responsibilities, resulting in improper enrollment in the Medicare zero-cost-share subtype. SNPs in states that provide cost-sharing for other categories of dual eligible beneficiaries, apart from QMBs and QMB+, may choose the Medicaid subset $0 cost-share subtype on the SNP application. SNPs would be permitted to enroll non-QMB or QMB+ beneficiaries in the Medicaid subset $0 cost-share SNP subtype, as long as the populations enrolled were consistent with the State Medicaid plan and te D-SNP state contract.

The draft instructions for the SNP Proposal state that an MA organization "currently offering a SNP that wants to expand the service area of this SNP must adhere to the same requirements for submission of an initial SNP proposal application." It appears that this policy would require that an existing SNP seeking a service area expansion (SAE), for example by adding one or two additional counties, must submit for approval a new Model of Care (MOC) for the expansion counties, even though the SNP's MOC has received a two or three year NCQA approval. It is our understanding that the MOC for the new counties is likely to reflect few, if any, differences compared to the MOC that has already been approved. The SNP approval process is extensive and rigorous and full review under these circumstances would be duplicative and resource intensive. Such a review could result in different findings than the prior review as a result of a change in reviewers, and for SNPs seeking to implement a consistent MOC across the entire service area, could potentially disrupt implementation of the previously approved MOC.	We believe a more reasonable approach would be to permit the MA organization to attest that the MOC applicable to the expansion counties would be unchanged from the already approved MOC for the existing service area, where this is the case, and apply the MOC to the new counties without further review or any change to the approval period. In the event that there may be differences, CMS should permit organizations to denote the sections of the MOC that include changes and require review only of the changed sections of the document. The original approval period would also continue to apply in this circumstance. CMS and NCQA used a similar approach to conduct further review of the portions of revised Models of Care resubmitted during the 2012 application cure process earlier this year. We recommend that CMS revise this section of the SNP Proposal and any other relevant sections to permit this process.	**Reject:** CMS disagrees with this recommendation to permit the MA organization to attest that the MOC applicable to the expansion counties would be unchanged from the already approved MOC for the existing service area, where this is the case, and apply the MOC to the new counties without further review or any change to the approval period. The Model of Care needs to reflect the specific population in the expanded service area (MOC element 1). Furthermore, CMS needs to determine that there is an adequate provider network for the population in the expanded service area (MOC elements 5, 6, and 9) .
The application instructions state that existing SNPs that require re-approval under the NCQA SNP Approval process should only submit the Model of Care written narrative and Model of Care Matrix Upload Document and will not be required to submit any other portion of the MA application or SNP proposal (unless specifically noted). The State Medicaid Agency contract submission requirements for renewal dual-eligible SNPs should be addressed in a manner similar to the MOC requirements (these are existing dual-eligible SNPs that are not expanding their service areas).	We recommend the instructions be revised to state that renewing dual-eligible SNPs be required to meet only the submission requirements for state contracts and will not be required to submit any other portions of the MA application or SNP proposal, unless specifically noted (e.g., in the instructions for submission of the MOC).	**Accept:** CMS revised the instructions in the ***Part C – Medicare Advantage and 1876 Cost Plan Expansion Application: APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals*** **to state that "existing dual eligible SNPs will need to a submit signed and executed State Medicaid Agency Contract in HPMS without submitting any other portions of the SNP proposal unless the existing D-SNP is changing its D-SNP subtype or applying for a Service Area Expansion."**

The instructions for the SNP proposal states that all 2013 Applicants seeking to offer a dual-eligible SNP must have a contract with the State Medicaid Agency from each State in which the SNP operates and notes that the requirement applies to "all initial, service area expansion and renewal dual-eligible SNP applicants."	We recommend the instructions in this section and in 2.4 be revised to state that such SNPs will be required to submit only the sections of the SNP proposal relating to state contracts (e.g., Section 6 - D-SNP State Medicaid Agency Contract) and other specifically designated portions of the SNP proposal (e.g., the Model of Care requirements) as needed, and that these SNPs will not be required to complete other portions of the MA Application or SNP proposal.	**Accept:** CMS revised the instructions in the Part C – Medicare Advantage and 1876 Cost Plan Expansion Application: APPENDIX I: Solicitations for Special Needs Plan (SNP) Proposals to state that "existing dual eligible SNPs will need to a submit signed and executed State Medicaid Agency Contract in HPMS without submitting any other portions of the SNP proposal unless the existing D-SNP is changing its D-SNP subtype or applying for a Service Area Expansion.
It is encouraging that CMS is developing operational policy that will reflect both State budgetary and contracting timelines and will align the dual-eligible SNP contract submission deadline with the MA contracting process (as stated in the CY 2012 Final Call Letter).	As the policies are developed, we recommend CMS retain a deadline for submission of contracts with State Medicaid agencies that is no earlier than the current deadline of July 1.	**Clarficiation:** The deadline for submitting a signed and executed State Medicaid Agency Contract remains the same as last year. The current deadline for submitting the State Medicaid Agency contracts is July 1, 2012.
The draft application states that all 2013 applicants seeking to offer a new severe or disabling chronic condition SNP or expand the service area of such an existing SNP must serve only individuals confirmed to have one of the CMS-approved chronic conditions. It is stated in the "2008 Special Needs Plan Chronic Condition Panel Final Report" that panelists "acknowledged that the present recommendations should be re-evaluated at the Secretary's discretion as Center for Medicare and Medicaid Services gathers evidence of the effectiveness of care coordination through the SNP product, and healthcare research demonstrates advancements in chronic condition management."	We recommend CMS move forward with such a re-evaluation, including considering additions to the CMS-approved list of chronic conditions. For example, CMS should consider the addition of combinations of conditions that reflect common patterns of co-morbidities.	**Clarification:** SNPs will need to continue to use the 15 current chronic conditions. However, CMS will consider moving forward with a re-evaluation of the 15 chronic conditions to include additional conditions or a combination of conditions that reflect common patterns of co-morbidities.

The revised definition of a zero-cost-share D-SNP indicates that such a SNP has a State Medicaid agency contract to limit enrollment to QMBs only and QMB+, "the two categories of dual eligible beneficiaries who are not financially responsible for cost sharing for Medicare Parts A or B." However, the categories of dual-eligible individuals for which a State may cover A/B cost sharing can vary by State and include categories in addition to QMBs and QMB+ (e.g., SLMB+ and Full Benefit Dual Eligible (FBDE) individuals).	We recommend CMS revise the definition to specify that a Zero Cost Share D-SNP also could cover other dual eligible beneficiaries that the State holds harmless for Part A and Part B cost sharing. The revision would be consistent with the version of the definition that was included in the 2012 Part C application.	**Reject with Clarficiation:** In order to be a Medicare zero-cost-share D-SNP, a SNP must only enroll QMB or QMB+ enrollees. These are the only categories of beneficiaries for which States are statutorily required to pay all Medicare Parts A&B cost-sharing. We do not include other categories of beneficiaries in this D-SNP subtype, because States may choose to change their cost-sharing responsibilities, resulting in improper enrollment in the Medicare zero-cost-share subtype. SNPs in states that provide cost-sharing for other categories of dual eligible beneficiaries, apart from QMBs and QMB+, may choose the Medicaid subset $0 cost-share subtype on the SNP application. SNPs would be permitted to enroll non-QMB or QMB+ beneficiaries in the Medicaid subset $0 cost-share SNP subtype, as long as the populations enrolled were consistent with the State Medicaid plan and te D-SNP state contract.