DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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TO: Medicare Advantage Organizations with a Dual Eligible Special Needs Plan

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SUBJECT: Medicare Managed Care Manual Chapter 16-B: Special Needs Plans: Updates on Cost-Sharing Requirements

The purpose of this memorandum is to share updates to section 20.2.4.1 of Chapter 16-B of the Medicare Managed Care Manual on cost sharing requirements for Dual Eligible Special Needs Plans (D-SNPs).

The updated section now better reflects current regulatory requirements in light of the recent Contract Year 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F). Where there are differences between statute or regulations and the manual, the statute or regulations control over the manual (and any other guidance). Therefore, stakeholders should consult the applicable statutes, regulations, and final rules.

Chapter 16-B, incorporating the updated section, is available at the following link: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf. The updates for this section are also in Attachment A.

Please email MMCO at MMCO_DSNPOperations@cms.hhs.gov and your CMS Account Manager with any questions.

Attachment A – Updates to 20.2.4.1

20.2.4 – Special Cost Sharing Requirements for D-SNPs

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

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 Part 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.