# States Benefit Integration and Contracting How To Guide

## I. Background and Purpose

The passage of the Medicare Improvements for Patients and Providers Act (MIPPA) in July 2008 yielded new opportunities to improve integration of Medicare and Medicaid benefits for dually eligible beneficiaries, specifically through specialized Medicare Advantage plans for dual eligibles (Dual SNPs). Specifically, MIPPA mandated that, effective January 1, 2010, Medicare Advantage (MA) organizations offering new Dual SNPs, or seeking to expand the service areas of existing Dual SNPs, enter into contractual relationships with States "to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under Title XIX."

Moreover, the March 2010 enactment of the Patient Protection and Affordable Care Act (PPACA) includes several provisions affecting the integration of Medicare and Medicaid benefits for dually eligible beneficiaries. The Act provides new requirements, some of which are addressed within this document, to support the goal of increased integration and coordination of Medicare and Medicaid services/benefits for dual eligible beneficiaries. Specifically, PPACA extended the authority for the continued operation of SNPs. Dual SNPs currently without an approved contract containing the contract elements outlined in MIPPA with its respective State Medicaid Agency may continue to operate through calendar year 2012. Dual SNPs with approved contracts may continue to operate through 2013. PPACA also mandated that beginning January 1, 2012, all SNPs must be approved by the National Committee for Quality Assurance.

To assist State Medicaid agencies in improving benefit integration through Dual SNPs, CMS has established a State Resource Center for addressing States' inquiries with respect to the coordination of State and Federal policies for Dual SNPs as well as for equipping States with helpful information as they engage in contract negotiations with MA organizations offering new or expanded Dual SNPs. As part of this effort, this "How To" document was created to address frequently encountered concerns and provide guidance to States regarding MIPPA contracting requirements, PPACA provisions and other benefit integration issues. Any questions related to this document may be submitted to the State Resource Center mailbox (State_Resource_Center@cms.hhs.gov).

## II. Contract Responsibilities

### 1. Which plans are required to have a contract with the State?

Only MA organizations seeking to offer new Dual SNPs or seeking service area expansions are required to have contracts with their State Medicaid agencies. For Calendar Year 2011, these contracts are due to CMS by September 1, 2010. Existing Dual SNPs that are not expanding their service areas may continue to operate, but have until December 31, 2012 to establish a contract with their State Medicaid agency. Beginning January 1, 2013, these State contracts must be in place for all Dual SNPs.

2. **Is it the State's responsibility to initiate a SNP contract?**
   No, this is not the State's responsibility. The MA organization should approach the State if it wants to either establish a new Dual SNP in the State or expand the service area of an existing SNP operating in the State.

3. **Must State Medicaid agencies contract with a Medicare Advantage Organization?**
   No, States are under no obligation to contract with a Medicare Advantage Organization for a Dual SNP. It is up to the Dual SNP to "make the case" that entering into such an agreement will be advantageous to the State. Contracting with an MA organization may be appropriate only as far as it supports the State's benefit integration strategy.

4. **If States wish to enter into Dual SNP contracts with some MA organizations, must the State contract with every MA organization who is interested in a contract?**
   No, States are not required to contract with any MA organization and may be selective about those with whom they choose to contract.

5. **Who is responsible for providing the care management services mandated by MIPPA?**
   Any MA organization offering a Special Needs Plan is required to meet the care management requirements in MIPPA section 164(d), including conducting an initial assessment and annual reassessment of the enrollee, developing an individualized care plan for each enrollee, using an interdisciplinary care management team and having an evidence-based model of care with appropriate networks of providers and specialists. States are not responsible for meeting MIPPA's care management requirements, providing payment to MA organizations for mandatory care management services, or for monitoring the MA organization's compliance with these requirements. However, States are responsible for monitoring the MA organization's adherence to the State/Dual SNP contract.

6. **Are States responsible for reviewing the Summary of Benefits?**
   CMS is ultimately responsible for approving each Summary of Benefits document. The Division of Special Programs is willing to assist States in developing and/or reviewing contracts and Summary of Benefits documents to ensure that they satisfy MIPPA requirements.

7. **May plans operating two dual eligible SNPs under different CMS H numbers (i.e., for example, H1001 and H1002), one with an approved contract with the State Medicaid Agency but the other without a contract, consolidate the two Dual SNPs under the SNP with the approved contract?**
   No. Additionally, an MA organization contracted with a State to offer a Dual SNP which restricts enrollment to only full benefit dual eligibles may not consolidate that SNP with a non-contracted Dual SNP which enrolls all categories of dual eligibles.

With CMS approval, plans may opt to consolidate multiple Dual SNPs under one contract with CMS only where all of the Dual SNPs under consideration for consolidation require the same eligibility criteria.

## III. Contract Design

**1. What are the minimum data that States and MA organizations need to share with one another? At minimum, what services must be provided by the MA organization?**

States may contract with MA organizations to provide Medicaid services ranging from minimal care coordination services to all the services to which the enrollee is entitled. To be compliant with MIPPA, the contract must, at minimum, describe the MA organization's responsibility to integrate and/or coordinate Medicare and Medicaid benefits. An administrative services agreement (i.e., an agreement in which the contracted MA organization provides solely administrative functions such as claims processing) will not be accepted by CMS as meeting MIPPA requirements. As such, States and MA organizations will be required to share sufficient data with each other to allow for the coordination and/or integration of Medicare and Medicaid benefits. CMS expects that this will include, at minimum, information on the providers contracted with the State Medicaid agency as well as information for verifying enrollees' Medicaid eligibility.

**2. Does money have to be exchanged between the MA organization and State Medicaid Agency?**

States are not required to provide payment to MA organizations. CMS expects that contracts will involve an exchange of value, which could consist solely of data-sharing and coordination of benefits. At minimum, contracts must include the provision of care coordination services. However, with the passage of the Patient Protection and Affordable Care Act, fully integrated Dual SNPs that are capitated and provide long-term care and other Medicaid services may receive payments based on PACE payment rules, as determined by the Secretary.

**3. If the State chooses not to contract direct Medicaid services to the SNP, does Medicaid provider information still need to be shared?**

States that choose to negotiate and award contracts to MA organizations for Dual SNPs must describe in the contract a process for the State to identify and share information on providers contracted with the State Medicaid agency, regardless of the level of Medicaid services provided by the Dual SNP. The State is under no obligation to monitor the degree to which the MA organization incorporates Medicaid providers into its SNP provider directory. However, such an arrangement is encouraged to facilitate a collaborative effort to provide services to dual eligible beneficiaries.

**4. What will the contract review process look like? Will this be separate from how other contracts are reviewed?**

If the SNP service area covers multiple States, MA organizations are required to submit a fully executed contract with each associated State. A "fully executed

contract" is defined as 1) being signed by the MA organization and the State Medicaid agency, 2) including all eight MIPPA elements identified in the July 17, 2009 HPMS memo, and 3) covering January 1 to December 31 of the applicable contract year.

In addition to submitting the executed contract, the MA organization is responsible for submitting a completed MIPPA Contract Matrix. For 2011, a more centralized method involving CMS Central Office may be put into place.

5. **Regarding the MIPPA requirement for the SNP to "provide or arrange" for Medicaid services, would directing the beneficiary to call their Medicaid managed care organization qualify?**

CMS recognizes that dual eligibles may be receiving all Medicaid benefits through a Medicaid managed care contractor that is entirely separate from the MA organization offering the SNP. In these cases, the SNP can provide minimal benefits, such as coordination of services or case management, that result in coordination of Medicare and Medicaid benefits for the dual eligible enrollee. Regardless of the extent of Medicaid services provided under the SNP, any contract between a State and an MA organization must explicitly describe how coordination will occur to ensure that enrollees receive all the Medicare and Medicaid benefits for which they are entitled. **Consequently, directing enrollees to call their Medicaid MCO will not meet the coordination threshold.**

6. **How are States expected to ensure Medicare and Medicaid benefits are integrated and/or coordinated? How would this work, exactly?**

As this is a new requirement under MIPPA, CMS anticipates it will work differently in different States. CMS is not mandating a specific process or contract for States to follow. However, in the spirit of MIPPA and the Patient Protection and Affordable Care Act, the goal is increased integration and coordination of Medicare and Medicaid services/benefits for dual eligible beneficiaries. Also, SNPs, under their Medicare contract, are required to meet the needs of their special needs populations in providing for appropriate care. These include such things as an evidence based model of care, specialized provider network, risk assessments for beneficiaries and use of interdisciplinary teams.

7. **Should the MAO contract with a care coordination organization?**

MA organizations are not required to contract with a care coordination organization though they are free to do so in order to meet the corresponding MIPPA requirement.

8. **What type of "shared information" on members who need services would the State need to make available?**

The State should agree to a process for the Dual SNP to verify an enrollee's Medicaid and Medicare eligibility status. Also, information should be shared with the Dual SNP to identify which providers accept Medicaid. The SNP network (for Medicare and Medicaid) should meet the needs of the special needs population.

### 9. Will CMS be developing and posting model contracts to the State Resource Center website?

Due to significant variability in Medicaid program designs and States' experiences in collaborating with Medicare Advantage organizations CMS has elected not to develop a model contract. Instead, CMS has developed a "State Options" paper that conveys several approaches States may elect to adopt for meeting each of the eight MIPPA contracting requirements. This document is available on the State Resource Center website (http://www.cms.gov/SpecialNeedsPlans/05_StateResourceCenter.asp).

### 10. How can less experienced States learn from more experienced States on Dual SNP contracting issues?

Several States have expressed interest in contacting other States directly to collaborate on dual SNP contracting issues. To assist States with this endeavor and foster collaboration, CMS has developed a shared State contact list available by request to the State Resource Center. If you would like to be on this list and obtain a copy, please send an e-mail to State_Resource_Center@cms.hhs.gov.

## IV. SNP Requirements

### 1. Have quality of care reporting requirements changed for SNPs?

Yes, these reporting requirements have changed. While all Medicare Advantage plans are still required to report Health Plan Employer Data and Information Set (HEDIS) performance measures to CMS, two new HEDIS measures specific to SNPs are now also required. CMS worked with the National Committee for Quality Assurance (NCQA) to develop these new SNP-specific measures. Reporting requirements vary depending on enrollment numbers and plan type.

In addition to the HEDIS measures, CMS and NCQA have also developed new Structure and Process measures in six areas specific to SNP plans. Both HEDIS and Structure and Process measures are required. Additional information may be found at: http://www.cms.hhs.gov/SpecialNeedsPlans/. Moreover, the Patient Protection and Affordable Care Act requires that, beginning in 2012, all Dual SNPs be approved by NCQA based on standards established by the Secretary. These standards have not yet been determined.

### 2. Do any quality reporting requirements specific to dual eligible SNPs exist?

No. While there are new SNP-only measures (both HEDIS and Structure and Process), these are required of all SNPs, not just Dual SNPs.

### 3. Must all MA organizations that enroll dual eligibles be designated as SNPs?

No, MA organizations that don't operate Dual SNPs may still enroll dual eligibles. However, only Dual SNPs can restrict enrollment to dual eligibles exclusively, which allows the SNP to develop benefit packages that better serve the dual eligible population.

### 4. Do SNPs provide the same benefit package as traditional fee-for-service Medicare? How can a State benefit from contracting with a SNP?

In order to offer an MA plan (including a SNP), the sponsoring MA organization must provide, at minimum, all Medicare benefits the enrollee would be entitled to under Original fee-for-service Medicare. MA organizations typically provide additional, i.e., supplemental, benefits not available under fee-for-service Medicare, and these benefits must be submitted to CMS as part of the Medicare bid process and approved before they may be offered to enrollees. Please refer to http://www.chcs.org/usr_doc/Medicare_Advantage_State_Primer.pdf for more information on the Medicare Advantage bidding process and rate setting.

States can negotiate with SNPs to influence what supplemental Medicare benefits the SNP will cover. This is an area where States can realize savings from integration – they can negotiate with the MA organization to have a Dual SNP cover some Medicaid services, such as vision and dental, for example, as supplemental *Medicare* benefits. As Medicare bids are due to CMS on the first Monday in June each year, State Medicaid Agencies should keep this date in mind in order to negotiate with an MA organization what Medicaid services can be covered as supplemental Medicare benefits for each plan year.