



**CMS 2010 BI-REGIONAL MEDICARE HEALTH PLAN COMPLIANCE  
CONFERENCE**  
**Boston & New York – Serving Our Beneficiaries Together**

Verbatim Transcript  
Special Needs Plans  
Heidi Arndt, MHA

>> NOW LET'S TURN OUR ATTENTION  
TO SPECIAL NEEDS PLANS.

HEIDI ARNDT IS OUR PRESENTER.

SHE IS THE DIRECTOR OF THE  
DIVISION OF MEDICARE ADVANTAGE

OPERATIONS, MEDICARE  
DRUG HEALTH PLAN CONTRACT

ADMINISTRATION GROUP.

THAT GIVES YOU A CLUE THAT  
SHE IS IN OUR CENTRAL

OFFICE AT CMS.

IN HER 7 YEARS AT CMS,  
HEIDI HAS WORKED IN VARIOUS

POSITIONS ACROSS 3 CENTERS  
AND THE REGIONAL OFFICE,

WITH RESPONSIBILITIES THAT  
HAVE INCLUDED THE MEDICARE FEE

SCHEDULE DEVELOPMENT AND  
OVERSIGHT OF LONG-TERM CARE

ENFORCEMENT AND STATE  
RELATIONS AND MEDICAID,

AND OVERSIGHT OF MEDICARE  
ADVANTAGE DEEMING

AND TARGETING  
APPEALS MONITORING.

SHE JOINED THE MEDICARE DRUG  
AND HEALTH PLAN ADMINISTRATION

GROUP AS A DIRECTOR OF THE  
DIVISION OF SPECIAL PROGRAMS

IN FEBRUARY 2009.

A YEAR LATER, HEIDI BECAME  
THE DIRECTOR OF THE DIVISION

OF MEDICARE OPERATIONS,  
AND SHE WAS ACTING

DIRECTOR OF THE DIVISION  
OF SPECIAL PROGRAMS.

PRIOR TO COMING TO CMS,  
HEIDI WORKED FOR ERNST & YOUNG

AS A HEALTH CARE CONSULTANT,  
THE GOVERNOR OF PENNSYLVANIA

AS A BUREAU DIRECTOR OF  
QUALITY, AND FOR TWO PRIVATE

INSURANCE PLANS OVERSEEING  
THE OPERATIONS OF MEDICARE

AND MEDICAID PRODUCTS.

HEIDI HAS A MASTER'S IN HEALTH  
ADMINISTRATION AND POLICY FROM

GEORGE WASHINGTON UNIVERSITY  
SCHOOL OF MEDICINE.

PLEASE WELCOME HEIDI ARNDT.

[APPLAUSE]

>> OK. WELL, THAT WAS  
QUITE A BUILD-UP.

THANK YOU VERY MUCH, AND THANK  
YOU TO THE NEW YORK REGIONAL

OFFICE FOR INVITING  
ME TO SPEAK TODAY.

AS I WAS PRINTING OUT MY  
SLIDES AND PULLING EVERYTHING

TOGETHER, OF COURSE AT THE  
LAST MINUTE, GRABBING THINGS

AS I WAS LEAVING THE HOUSE,  
I DIDN'T REALIZE UNTIL I WAS

ON THE TRAIN THAT I HAD  
ACTUALLY INTERSPERSED SOME

HANNAH MONTANA FUN FINGER  
PAINTS WITHIN MY PRESENTATION.

BUT IT HELPED ME TO REMEMBER  
WHY WE ARE ALL DOING THIS,

WHY WE'RE IN THIS ROOM, WHY  
WE ARE PARTICIPATING IN THIS

PROGRAM, AND IT'S ABOUT THE  
PEOPLE THAT WE SERVE, AND AS I

THINK ABOUT THE WORK THAT I'M  
DOING NOW, I'M HOPING THAT I'M

HELPING TO BUILD A FOUNDATION  
OF A PUBLIC PROGRAM THAT WILL

BE AVAILABLE FOR MY CHILDREN  
IF THEY SO CHOOSE.

AND, YOU KNOW, AS WE LOOK AT  
THE TRUST FUND AND HAVING TO

ENSURE THAT WE ARE GOOD TRUSTEES

OF THAT FUND, THAT WE'RE

MANAGING A PROGRAM THAT IS  
YIELDING GOOD QUALITY OUTCOMES

AND THAT THE PEOPLE THAT ARE  
RECEIVING THESE SERVICES FEEL

THAT THEY'RE RECEIVING QUALITY  
OUTCOMES AND THAT WE ARE

PARTNERING WITH CONTRACTORS  
WHO SHARE THE SAME MISSION

AND THE SAME DRIVE TO HAVE A  
PROGRAM THAT IS WORTHWHILE

AND FORTIFIED.

SO AS THE WINDS OF POLITICAL  
CHANGE MOVE OUR PROGRAM FROM

SIDE TO SIDE, I THINK THAT WE  
ARE BUILDING A GOOD ENGINEERED

SUSPENSION THAT WILL KEEP  
THE FOUNDATION MOVING FORWARD

AND CONTINUE GROWING.

THIS MORNING I'D LIKE TO  
FOCUS ON SPECIAL NEEDS PLANS

AND SPECIFICALLY THE  
2010 SNP LANDSCAPE.

WHAT DO WE LOOK LIKE TODAY  
VERSUS WHAT WE LOOKED LIKE

LAST YEAR?

SOME OF THE LEGISLATIVE  
UPDATES AND SOME

OF THE PROJECTS AND CHANGES  
THAT CMS IS PLANNING FOR 2010

GOING FORWARD.

AS YOU KNOW, IN 2009,

WE NEEDED TO MAKE

A LOT OF CHANGES.

WE NEEDED TO NARROW THE SCOPE  
OF CHRONIC CONDITIONS THAT

SPECIAL NEEDS PLANS  
COULD PARTICIPATE IN.

WE ALSO HAD TO PUT IN PLACE  
SOME STANDARDS FOR CONTRACTING

FOR DUAL SNPs THAT WANTED TO  
EITHER EXPAND THEIR SERVICE

AREA OR CREATE NEW PLANS.

WE NEEDED TO REACH OUT TO THE  
STATES WHERE THEY PARTICIPATED

AND CONTRACT, AND SO SOME  
OF THOSE THINGS THAT WE PUT

IN PLACE ACTUALLY NARROWED THE  
NUMBER OF SPECIAL NEEDS PLANS

THAT NOW EXIST.

SO IN 2009, WE HAD MORE THAN  
700 SPECIAL NEEDS PLANS,

AND IN CONTRACT YEAR 2010,  
WE ARE DOWN TO 544 PLANS.

AND YOU CAN SEE THE BREAKOUT.

THE MAJORITY OF THE MEMBERS  
THAT ARE ENROLLED IN SPECIAL

NEEDS PLANS ARE ENROLLED  
IN DUAL ELIGIBLE PLANS.

AND I HAVE A COUPLE OF THESE  
SLIDES THAT JUST KIND OF SHOW

YOU THE PENETRATION.

THE YELLOW IS TELLING YOU THAT  
THERE ARE ZERO SPECIAL NEEDS

PLANS IN THOSE  
GEOGRAPHIC AREAS.

SO YOU CAN SEE  
WHERE THEY FALL.

DUAL ELIGIBLE SNPs--THERE ARE  
QUITE A FEW MORE THAN CHRONIC

SNPs, BUT AGAIN, YOU SEE THE  
SAME--THE YELLOW AREA WHERE

VERY LITTLE TO NO PENETRATION.

AND THOSE ARE SOME OF THE  
THINGS THAT WE'RE STARTING TO

LOOK AT AND STARTING TO  
REACH OUT TO STATES TO TALK

ABOUT WHY SPECIAL NEEDS PLANS  
ARE IMPORTANT, POSSIBLY,

TO THEIR MEDICAID STRATEGIES.

WE HAVE VERY FEW INSTITUTIONAL  
SNPs, AS YOU CAN SEE.

AND THEN THE PENETRATION  
FOR CHRONIC SNPs.

HEALTH CARE REFORM MADE  
SEVERAL CHANGES TO OUR OVERALL

PROGRAM, AND FOR SNPs,  
SPECIFICALLY IT CHANGED

THE DATE FOR THE SUNSET FOR  
SPECIAL NEEDS PLANS TO

JANUARY 1, 2014.

SPECIAL NEEDS PLANS

WERE SUPPOSED TO SUNSET

DECEMBER 31, 2010.

SO THE HEALTH CARE REFORM

LEGISLATION ACTUALLY ADDED

A COUPLE MORE YEARS.

ALSO, ONE OF THE OTHER  
THINGS THAT WE WERE PREPARING

FOR IN 2009 WAS THAT ALL DUAL  
SNPs WERE SUPPOSED TO HAVE

A CONTRACT WITH STATE MEDICAID  
AGENCIES BY THE END

OF THIS YEAR.

THAT AGAIN WAS CHANGED IN  
THE NEW LEGISLATION, AND IT'S

ALLOWING PLANS ANOTHER  
COUPLE OF YEARS TO CONTRACT

WITH STATES BUT NOT TAKING  
AWAY THE REASONS

FOR DOING THIS.

CONGRESS IS VERY INTERESTED  
IN DUAL SNPs HAVING SECURE,

FULFILLING RELATIONSHIPS  
WITH STATE MEDICAID AGENCIES.

THE REASONS WHY, OF COURSE,  
ARE BECAUSE MEMBERS WILL

RECEIVE BETTER SERVICES IF  
THERE'S SOME INTEGRATION

BETWEEN MEDICAID AND MEDICARE.

SO IT IS INCREASINGLY  
IMPORTANT THAT PLANS BEGIN TO

WORK WITH STATE MEDICAID  
AGENCIES AND DEVELOP

INTEGRATED MODELS THAT  
WILL ENSURE THAT PEOPLE ARE

ACTUALLY RECEIVING A  
SEAMLESS DELIVERY OF SERVICES.

I JUST WANTED TO HIGHLIGHT A  
COUPLE OF THE THINGS THAT WE

MANDATE MUST BE IN  
STATE CONTRACTS.

ONE, OF COURSE, IS THAT YOU  
MUST SPECIFICALLY TELL US

THE POPULATION THAT YOU'RE  
PLANNING TO SERVE.

WE HAVE HAD A COUPLE OF  
INSTANCES WHERE WE'VE PROVIDED

A LOT OF TECHNICAL ASSISTANCE  
TO PLANS AND TO STATES TO HELP

THEM IDENTIFY THE POPULATION  
THAT THE PLAN IS ACTUALLY

GOING TO SERVE AND WHY IT'S  
IMPORTANT TO LET US KNOW

AND TO BE VERY  
SPECIFIC ABOUT THAT.

THE STRUCTURE OF THE  
CONTRACTUAL ARRANGEMENT IS

ALSO INCREDIBLY IMPORTANT.

WILL THE PLAN OFFER MEDICAID  
BENEFITS IN ADDITION TO

THE MEDICARE BENEFITS  
THAT THEY'RE OFFERING?

AT WHAT LEVEL WILL THE  
PLAN OFFER THOSE BENEFITS?

WILL THE BENEFITS BE FULLY  
INTEGRATED, OR WILL THERE BE

A PARTIAL INTEGRATION?

MANY STATES CARVE OUT CERTAIN

SERVICES LIKE MENTAL HEALTH

AND LONG-TERM CARE, AND OTHER  
STATES LIKE TO THROW THAT INTO

THE CONTRACT.

THOSE THINGS ARE VERY  
IMPORTANT TO KNOW.

AND SOME CONTRACTS ARE NOT  
AS FORTIFIED AS THAT.

YOU KNOW, SOME ARE REALLY,  
RIGHT NOW, ARRANGEMENTS WHERE

COMMUNICATION BETWEEN THE  
PLAN AND THE STATE IS SOLID

AND THAT THERE'S INFORMATION  
BEING PASSED BACK AND FORTH

AND THAT MEMBERS' NEEDS ARE  
BEING DISCUSSED BETWEEN

THE TWO AGENCIES.

SO THERE MAY NOT BE AN  
INTEGRATION OF SERVICES,

BUT THERE SHOULD BE AN  
INTEGRATION OF COMMUNICATION.

THIS FIRST BULLET IS,

OF COURSE, A QUESTION THAT

SNPs ARE HAVING AND THAT CMS

IS PONDERING AT THIS MOMENT.

IN THE LEGISLATION,

THE CONGRESS IS MANDATING THAT

SPECIAL NEEDS PLANS GO THROUGH

AN APPROVAL PROCESS THAT WILL

BE MANAGED BY NCQA.

AND MANY PEOPLE WANT TO KNOW,  
WHAT IS THAT, AND WHAT WILL  
THAT INCLUDE?  
RIGHT NOW, OF COURSE, NCQA  
COLLECTS OUR SNP-SPECIFIC  
HEDIS MEASURES AND STRUCTURE  
AND PROCESS MEASURES,  
AND A LOT OF QUESTIONS HAVE  
COME UP AROUND THOSE MEASURES  
AND THOSE HEDIS STANDARDS,  
AND WILL THAT BE A PART  
OF THAT APPROVAL PROCESS?  
AND WHERE WE ARE LEANING AT  
THIS MOMENT IS TO USE THE SAME  
TYPE OF PROCESS THAT WE  
CURRENTLY USE TO BRING NEW  
SNPs INTO THE PROGRAM.  
SO WE USUALLY COLLECT  
INFORMATION THAT FOCUSES  
ON THEIR MODEL OF CARE,  
IMPLEMENTATION, QUALITY  
IMPROVEMENT PROGRAM, OF COURSE  
CONTRACT ELEMENTS THAT THEY  
MAY HAVE WITH THE STATE  
MEDICAID AGENCIES, SO THOSE

ARE SOME OF THE AREAS THAT  
WE WILL FOCUS ON AS WE'RE  
DEVELOPING AN APPROVAL  
PROCESS FOR NCQA.

AND THESE ARE THINGS THAT  
PLANS ALREADY HAVE IN PLACE  
AND ARE CONTINUING TO BUILD  
AND I BELIEVE WILL BE NOT  
NECESSARILY AN EASIER WAY  
TO WORK THROUGH THE APPROVAL  
PROCESS, BUT IT'S A WAY THAT  
YOU'RE ALREADY PERFORMING  
A LOT OF THESE PROCESSES.

WE'RE ALREADY COLLECTING A  
LOT OF INFORMATION ABOUT YOUR  
MODELS OF CARE AND  
QUALITY IMPROVEMENT.

AND SO NCQA WILL THEN  
ASSIST US WITH REVIEWING  
THOSE ELEMENTS.

AND THEN THE FINAL PIECE OF  
HEALTH CARE REFORM REALLY HAS  
TO DO WITH EVALUATION, AND  
WE ARE CONSTANTLY EVALUATING  
SPECIAL NEEDS PLANS AND THE  
OVERALL PROGRAM, AND SO THIS

IS SOMETHING THAT CONGRESS  
WANTS TO MAKE MORE FORMAL.

SOME OF THE PROJECTS THAT WE  
ARE PLANNING FOR 2010 AND INTO

2011 INCLUDE LOOKING AT OUR  
QUALITY IMPROVEMENT STRUCTURE

AND HOW WE RELATE TO MEDICARE  
ADVANTAGE ORGANIZATIONS

SPECIFICALLY AND THEN SOME  
PIECES THAT FALL UNDER SPECIAL

NEEDS PLANS.

MODEL OF CARE FACT FINDING.

WE ARE INVESTIGATING HOW PLANS  
IMPLEMENT MODELS OF CARE.

AND THIS IS NOT  
AN AUDIT PROCESS.

THIS IS REALLY JUST  
PURE FACT FINDING.

WE WILL BE SENDING CMS STAFF  
AS WELL AS CONTRACTUAL STAFF

OUT TO VISIT PLANS AND LET  
THE PLAN WALK US THROUGH THEIR

MODEL OF CARE PROCESS.

WE'RE TRYING TO IDENTIFY  
SOME BEST PRACTICES.

WE'RE TRYING TO ALSO IDENTIFY  
WHETHER OR NOT THE STANDARDS

THAT WE ARE PUTTING IN PLACE  
ARE REALISTIC AND ARE HELPFUL.

THE NEXT ITEM IS TO IDENTIFY  
RECOMMENDED SPECIALIZED

PROVIDER NETWORKS.

I THINK THAT WE STILL ARE  
QUESTIONING THAT IN ORDER TO

BE A SPECIAL NEEDS PLAN,  
OF COURSE YOU MUST BE SPECIAL

IN SOME WAY, AND  
WHAT DOES THAT MEAN?

AND ONE OF THE COMPONENTS  
COULD BE THAT YOUR PROVIDER

NETWORK SHOULD BE STRUCTURED  
IN A WAY THAT SPECIFICALLY

MEETS THE NEEDS OF THE  
INDIVIDUALS THAT YOU'RE

SERVING UNDER YOUR SPECIAL  
NEEDS PLAN, AND IT MAY LOOK

A LITTLE DIFFERENT FROM A  
REGULAR MEDICARE ADVANTAGE

PLAN, BUT THOSE ARE SOME  
OF THE THINGS THAT WE ARE

CURRENTLY EXPLORING AND  
REACHING OUT TO THE INDUSTRY

TO GET MORE INFORMATION ON.

AND THEN OF COURSE,  
AS I MENTIONED BEFORE,

THE OVERALL PROGRAM ANALYSIS.

IF WE TALK ABOUT QUALITY  
IMPROVEMENT SPECIFICALLY,

WE ARE IN THE PROCESS OF  
DEVELOPING AN OVERALL STRATEGY

THAT WILL BE USED AT  
MANY DIFFERENT LEVELS

OF THE MEDICARE  
ADVANTAGE OPERATIONS.

AS WE THINK ABOUT SPECIAL  
NEEDS PLANS, WE KNOW THAT ONE

OF THE THINGS THAT WE HEAR  
PRETTY REGULARLY IS THAT CMS

IS COLLECTING CERTAIN DATA  
AND EXPECTING CERTAIN THINGS,

AND THEN THE STATES ARE  
COLLECTING CERTAIN DATA

AND EXPECTING CERTAIN THINGS,  
AND THE INFORMATION NEVER

QUITE MEETS IN THE MIDDLE,  
THAT THERE IS A DUPLICATION

OF EFFORT AND PERHAPS THE  
PLANS ARE HAVING TO USE

RESOURCES THAT THEY COULD PUT  
BACK INTO THE PROGRAM ITSELF

TO ENSURE THAT THEY'RE JUMPING  
THROUGH ALL THE RIGHT HOOPS

FOR CMS AND ALSO THE STATE.

SO WE ARE DOING SOME RESEARCH.

WE ACTUALLY STARTED A YEAR  
AGO TO LOOK AT WHAT STATES ARE

REQUESTING AND WHAT THEIR  
EXPECTATIONS ARE AND HOW THOSE

EXPECTATIONS COMPARE TO  
WHAT OUR EXPECTATIONS ARE.

SO THAT'S SOMETHING THAT  
WE'RE DOING THAT'S AN ONGOING

PROCESS, AND WE WELCOME  
INFORMATION FROM PLANS.

I KNOW THAT THE SNP ALLIANCE  
IS ALSO DOING A LOT OF WORK

AROUND THAT.

WE ARE ALSO LOOKING AT OUR QIP  
AND CCIP EVALUATION PROCESSES

AND FINE-TUNING THEM,  
PROVIDING MORE TECHNICAL

ASSISTANCE TO PLANS SO THAT  
YOU UNDERSTAND WHAT WE'RE

LOOKING FOR AND WHY YOU MAY  
HAVE RECEIVED A RATING THAT

YOU RECEIVED.

AND THIS IS  
ACTUALLY WHAT

I JUST SPOKE ABOUT.

BOOZ ALLEN IS ONE OF OUR

CONTRACTORS THAT WORKS WITH US

ON SPECIAL NEEDS PLANS,

AND SPECIFICALLY THEY SET UP

OUR STATE RESOURCE CENTER THAT

WAS MANDATED IN THE MIPPA

LEGISLATION IN 2008.

THEY ARE, ALONG WITH US,

WORKING VERY CLOSELY

WITH STATES TO HELP THEM WALK

THROUGH THE PROCESS OF WORKING

WITH MEDICARE ADVANTAGE PLANS.

SOMETIMES THIS IS A PROCESS

THAT'S VERY INTIMIDATING TO

STATES BECAUSE THEY MAY NOT

UNDERSTAND ALL THE MEDICARE  
RULES, WHICH ARE QUITE  
DIFFERENT FROM MEDICAID,  
AND TRYING TO MARRY THE  
TWO AND FIT IN WITH THEIR  
LEGISLATIVE PROCESSES AND  
THEIR TIMING HAS BEEN SOMETIMES  
VERY DIFFICULT FOR THEM.

SO BOOZ ALLEN WORKS WITH US  
TO WORK WITH THE STATES.

BACK TO THE MODEL OF  
CARE FACT-FINDING.

AGAIN, THIS IS NOT AN AUDIT.

THIS IS REALLY SOMETHING THAT  
WE THINK WILL NOT ONLY HELP

CMS, BUT IT WILL ALSO HELP  
THE INDUSTRY, AND TRYING TO

IDENTIFY THE GOLD STANDARD FOR  
MODELS OF CARE, IDENTIFYING

BEST PRACTICES THAT CAN BE  
SHARED AND USED AMONG PROGRAMS

IS VERY IMPORTANT.

AND I'VE JUST LISTED A FEW OF  
THE THINGS THAT WE'RE GOING TO

BE LOOKING AT.

MEDICAL MANAGEMENT SYSTEMS  
ARE INCREDIBLY IMPORTANT,

AND DEPENDING ON THE  
SOPHISTICATION OF THOSE

SYSTEMS, YOU CAN SEE THE TYPE  
OF DATA THAT CAN COME OUT

OF THAT INFORMATION.

THAT THEN CAN BE USED  
FOR QUALITY IMPROVEMENT.

IT CAN BE USED TO ENHANCE  
PROGRAMS AND ENHANCE OUTCOMES

AND PARTNERSHIPS WITHIN  
COMMUNITY-BASED ORGANIZATIONS.

SO IT'S VERY IMPORTANT, BUT  
WE KNOW THAT EVERY PLAN IS

AT A DIFFERENT LEVEL WITH  
INFORMATION SYSTEMS.

AND THE REVIEW OF UTILIZATION  
MANAGEMENT AND TRANSITIONS

OF CARE ARE ALSO INCREDIBLY  
IMPORTANT TO SPECIAL NEEDS

PLANS AND REALLY TO OVERALL  
MEDICARE ADVANTAGE.

AND WE'RE INTERESTED IN  
FINDING OUT HOW SUCCESSFUL YOU

ARE AT TRANSITIONS OF CARE,  
AND ARE PEOPLE REHOSPITALIZED

BECAUSE, YOU KNOW,  
IF SOMETHING FALLS THROUGH THE

CRACKS AND YOU DON'T HAVE THE  
HOME HEALTH PEOPLE OUT TO

THE HOME IN TIME.

SO, WHAT ACTUALLY OCCURS  
WITHIN YOUR MODEL THAT IS

A SUCCESS, AND WHAT HAS  
HAPPENED THAT MAY HAVE

PROVIDED SOME CHALLENGES TO  
YOUR MODEL AND THEN, WHAT DID

YOU DO TO FIX IT?

AND SO IT'S REALLY  
A CONVERSATION

ABOUT THE IMPLEMENTATION  
OF YOUR MODEL OF CARE.

OK.

ONE OF THE THINGS THAT WE ARE  
VERY INTERESTED IN DOING IS

GOING OUT ON A HOME VISIT FOR  
THOSE PLANS THAT ACTUALLY DO

HOME VISITS.

IT'S INTERESTING TO TALK TO A  
MEMBER ABOUT THE SERVICES THAT

THEY ARE RECEIVING.

I HAVE BEEN ON, NOW, 6  
HOME VISITS WITH A FEW

DIFFERENT PLANS.

AND YOU GET A DIFFERENT  
PERSPECTIVE OF THE PLAN

AND THEIR MODEL OF CARE,  
SO THAT'S ONE OF THE THINGS

THAT WE'RE VERY INTERESTED IN.

MANY OF YOU HAVE HEARD MY  
MODEL OF CARE PRESENTATION

MANY DIFFERENT WAYS IN  
DIFFERENT PLACES, AND I THINK,

YOU KNOW, WE TALK  
ABOUT THE SAME THINGS.

WE TALK ABOUT THE GOALS THAT  
WE HAVE FOR THIS PARTICULAR

COMPONENT OF THE PROGRAM.

WE TALK ABOUT THE  
COMPONENTS THAT WE EXPECT TO  
HAVE IN PLACE.

AND EVEN THOUGH I ALWAYS  
SEEM TO FOCUS ON THE SAME

INFORMATION, THERE IS ALWAYS A  
DIFFERENT INTERPRETATION THAT

COMES OUT OF THAT PRESENTATION  
FROM DIFFERENT PLANS,

AND SO IT'S KIND OF INTERESTING  
TO TALK TO PEOPLE AFTER

THE PRESENTATION TO HEAR  
WHAT THEIR INTERPRETATION

OF THINGS... YOU KNOW, ONE OF  
THE MYTHS THAT'S OUT THERE IS

THAT CMS EXPECTS MODELS OF  
CARE TO LOOK EXACTLY THE SAME

WAY ACROSS THE INDUSTRY,  
AND THAT IS NOT

OUR EXPECTATION.

ONE SIZE DOES NOT FIT ALL,  
AND WE KNOW THAT.

GEOGRAPHICALLY THERE ARE  
CHANGES, POPULATION-SPECIFIC

CHANGES, DIFFERENT PLANS  
OPERATE IN DIFFERENT WAYS.

SO WE UNDERSTAND THAT YOUR  
MODEL OF CARE IS NOT GOING TO

LOOK EXACTLY THE  
SAME AS PLAN "B."

IN FACT, WE WOULD ENCOURAGE

YOU TO STRUCTURE YOUR MODEL  
OF CARE SPECIFIC TO THE NEEDS  
THAT YOUR POPULATION AND YOUR  
ORGANIZATION HAS.

SO SOME OF THE GOALS INCLUDE  
IMPROVING ACCESS TO SERVICES,  
WHETHER THEY'RE MENTAL HEALTH  
OR SOCIAL SERVICES, MEDICAL  
SERVICES, AFFORDABLE CARE,  
IMPROVED COORDINATION OF CARE,  
TRANSITIONS THAT WE TALKED  
ABOUT EARLIER, AND ACCESS TO  
PREVENTIVE SERVICES.

ASSURE APPROPRIATE  
UTILIZATION OF SERVICES,  
WHETHER YOU'RE LOOKING  
AT OVERUTILIZATION  
OR UNDERUTILIZATION.

ASSURE COST-EFFECTIVE  
SERVICE DELIVERY.

NOW REALLY PAYING ATTENTION  
TO WHERE SERVICES SHOULD BE  
PROVIDED, WHETHER IT'S IN THE  
COMMUNITY OR IN AN INSTITUTION  
BUT BEING VERY CAREFUL ABOUT  
HOW YOU EVALUATE WHERE THOSE

SERVICES ARE PROVIDED.  
AND THEN OF COURSE IMPROVING  
HEALTH OUTCOMES--LOOKING  
AT PAIN MANAGEMENT AND  
MOBILITY AND ASSESSING  
FUNCTIONAL STATUS  
ON A REGULAR BASIS.  
SO WE BELIEVE THAT THE  
MODEL OF CARE TRULY IS  
THE ARCHITECTURE FOR MANAGING  
SOMEONE'S NEEDS, AND I'M FROM  
THE SCHOOL OF THOUGHT THAT  
A MANAGED CARE ORGANIZATION  
SHOULD HAVE A VERY STRONG  
MODEL OF CARE--NOT JUST  
A SPECIAL NEEDS PLAN BUT A  
MANAGED CARE ORGANIZATION,  
AND I THINK THAT WE STARTED  
OUT THAT WAY AND OVER THE  
YEARS THINGS HAVE CHANGED,  
BOTH LEGISLATIVELY AND ALSO  
JUST IN THE INDUSTRY, THAT MAY  
HAVE WATERED DOWN A LITTLE BIT  
MODELS OF CARE IN REGULAR  
MANAGED CARE ORGANIZATIONS.

BUT WHAT I THINK WE'RE HOPING  
IS THAT SPECIAL NEEDS PLANS  
WILL NOW START THAT PATH AGAIN  
TOWARDS GOOD CARE MANAGEMENT  
AND A MODEL OF CARE THAT HAS  
IDENTIFIED BEST PRACTICES CAN  
BE USED FOR GOOD DISEASE  
MANAGEMENT GOING FORWARD  
AND FOR ALL PLANS.

AND THESE ARE THE MODEL OF  
CARE ELEMENTS THAT WE HAVE  
PUBLISHED AND POSTED AND  
DISCUSSED OVER THE LAST COUPLE  
OF YEARS, AND, YOU KNOW,  
THEY'RE PRETTY SELF-EXPLANATORY.

THERE SHOULD BE  
MEASURABLE GOALS.

EVERYBODY KNOWS THAT.

THAT CONNECTS DOWN TO THE CARE  
PLAN AND THEN MOVES INTO  
THE CARE MANAGEMENT ROLES,  
THE STAFF THAT YOU HAVE  
INVOLVED, THE PEOPLE  
THAT ARE WORKING ON YOUR  
INTERDISCIPLINARY TEAM,

AND AGAIN GOING BACK TO A MYTH,  
WE ARE NOT EXPECTING THAT  
YOU HAVE, LIKE, A PACE MODEL,  
PEOPLE SITTING IN A ROOM  
EVERY DAY AND HAVING  
INTERDISCIPLINARY TEAM MEETINGS.  
THAT'S NOT ALWAYS  
SOMETHING THAT YOU CAN DO.  
BUT THERE SHOULD BE A WAY TO  
HAVE A VIRTUAL TEAM THAT CAN  
INFLUENCE EACH OTHER IN  
DECISION-MAKING, CAN WORK  
WITH THE MEMBER IN DEVELOPING  
CARE PLAN GOALS AND CAN AID  
IN GOOD OUTCOMES.  
MODEL OF CARE TRAINING IS  
INCREDIBLY ESSENTIAL, AND I  
THINK ANOTHER MYTH THAT I  
HEARD LAST YEAR WAS THAT WE  
EXPECTED A PLAN TO GO OUT AND  
TRAIN EACH AND EVERY PROVIDER  
THAT THEY HAVE IN PERSON FACE-  
TO-FACE AND SO, AS AN OLD PLAN  
MANAGER, IF I THOUGHT ABOUT  
HAVING TO GO OUT AND

TRAIN THOUSANDS OF PROVIDERS  
INDIVIDUALLY, THAT'S PROBABLY  
NOT VERY PRACTICAL.

BUT WHAT WE DO EXPECT IS THAT  
YOU HAVE A PROCESS IN PLACE  
THAT DISSEMINATES INFORMATION  
THAT YOU CAN ENSURE YOUR  
PROVIDERS ARE ON BOARD WITH  
THE WAY THAT YOU MANAGE THE  
CARE OF YOUR MEMBERS--THAT  
THEY UNDERSTAND IT,  
THAT THERE'S A PROCESS IN  
PLACE FOR COMMUNICATION FROM  
THE PROVIDER IF THERE ARE  
QUESTIONS AND THAT MAYBE  
THERE'S SOME WAY OF  
GETTING INFORMATION OUT  
ON A REGULAR BASIS.

SO AS I WRAP UP THE DISCUSSION  
ABOUT SPECIAL NEEDS PLANS,  
I FIRST WANT TO JUST LET YOU  
KNOW THAT WHERE WE'RE HOPING  
TO MOVE IS THAT WE HAVE  
SPECIFIC AUDIT ELEMENTS,  
MONITORING ELEMENTS THAT WILL

FOCUS ON SPECIAL NEEDS PLANS  
AND THE NEEDS OF THE  
POPULATIONS THAT ARE  
ENROLLED, AND, YOU KNOW,  
AS WE LOOK FORWARD AND WE LOOK  
AT--IF WE THINK ABOUT THOSE  
MAPS AND WE SEE THE DIRECTION  
OF SPECIAL NEEDS PLANS,  
THEY'RE MOVING INTO MORE  
DUAL POPULATIONS, AND THAT IS  
BECOMING INCREASINGLY  
IMPORTANT BOTH IN OUR AGENCY  
AND ALSO AROUND THE COUNTRY.  
HOW DO WE MANAGE THE NEEDS  
OF DUAL ELIGIBLES?  
WHAT ARE THE PIECES THAT ARE  
INCREDIBLY IMPORTANT TO ENSURE  
THAT THOSE MEMBERS ARE ABLE TO  
RECEIVE THE SERVICES THAT THEY  
NEED WHEN THEY NEED THEM IN  
THE TIME THAT THEY NEED THEM  
AND THAT YIELDS A GOOD OUTCOME?  
SO, YOU KNOW, I THINK THAT  
AS WE START THINKING  
ABOUT MONITORING AND HOW

WE WOULD EVALUATE THE  
EFFECTIVENESS OF THIS PROGRAM,  
WE'RE STARTING TO LOOK AT SOME  
OF THOSE COMPONENTS.  
WE'RE LOOKING AT CARE  
MANAGEMENT MODELS AND PLANS  
AND THE DOCUMENTATION OF HOW  
YOU IMPLEMENT CARE MANAGEMENT.  
WHAT ARE YOU DOING TO  
REVIEW YOUR OWN PROCESSES  
ON A REGULAR BASIS?  
HOW ARE YOU IDENTIFYING  
WHERE YOU HAVE CHALLENGES  
IN OUTCOMES?  
AND THEN PUTTING IN PLACE  
QUALITY IMPROVEMENT PROCESSES  
AND PROGRAMS AND PROJECTS THAT  
WILL THEN BE FURTHER EVALUATED  
TO ENSURE THAT THEY'RE  
ACTUALLY WORKING.  
SO THESE ARE THE THINGS THAT  
WE'RE LOOKING TO YOU TO DO,  
AND THEN OF COURSE THAT  
YOU'RE JUST COMPLYING  
WITH THE REPORTING

REQUIREMENTS THAT WE HAVE.

SOMETIMES THEY CAN BE TEDIOUS

IN YOUR MIND, BUT THE DATA

THAT WE COLLECT REALLY

HELPS US TO IDENTIFY SOME

OF THE SHORTCOMINGS IN

OUR PROGRAM, AND IT'S

INCREDIBLY IMPORTANT.

THANK YOU VERY MUCH.

[APPLAUSE]

OK. ANY QUESTIONS?

>> MY NAME IS  
MICHAEL HUGHSMAN.

I'M FROM HEALTHFIRST HERE  
IN NEW YORK, AND I HAVE TWO

QUESTIONS, ACTUALLY.

THE FIRST ONE IS, ARE YOUR  
SLIDES GOING TO BE AVAILABLE

ON THE WEBSITE?

THEY WEREN'T THERE YESTERDAY.

>> THEY WILL BE, YES.

>> OK. AND THEN THE SECOND  
QUESTION I HAVE, AND IT WAS

EITHER THE CALL LETTER  
OR PPACA OR CMS-4085.

THEY'RE ALL KIND OF  
SWIRLING AROUND IN MY HEAD.

SO THERE WAS A NOTIFICATION

THAT WE HAD TO IDENTIFY SNP

MEMBERS THAT DON'T MEET  
THE ELIGIBILITY CRITERIA

FOR THE SNP AND THAT WE HAD TO  
REPORT THOSE MEMBERS TO CMS BY

JUNE 30 AND THEN PROCEED TO  
DISENROLL THEM, AND TO MY

KNOWLEDGE, THERE HASN'T BEEN  
ANY FURTHER COMMUNICATION

ON THAT, SO I WAS WONDERING  
WHAT THE PLAN IS FOR THAT.

>> I BELIEVE THAT THERE  
MAY HAVE BEEN AN HPMS MEMO

IN APRIL THAT WENT OUT  
TO FURTHER DISCUSS THAT

INFORMATION, BUT IF YOU NEED  
SOME ADDITIONAL INFORMATION,

YOU CAN CERTAINLY CALL ME.

>> OK, BECAUSE I MEAN,  
I THINK ALL

THAT MEMO SAID, IF I RECALL,  
WAS THAT IT EXTENDED THE

DEADLINE BECAUSE I THINK IT  
WAS ORIGINALLY MARCH THAT WE

HAD TO IDENTIFY  
THOSE PEOPLE.

>> OK.

>> IT WAS JUST BASICALLY  
EXTENDING IT TILL JUNE 30.

>> RIGHT, AND I  
KNOW THAT OUR

CHAPTER TWO  
FOR ENROLLMENT

POLICY WAS ALSO UPDATED IN  
SEPTEMBER TO FOCUS ON SOME

OF THOSE ISSUES, BUT AGAIN,  
IF IT'S NOT CLEAR, PLEASE JUST

GIVE US A CALL, AND WE  
CAN ANSWER YOUR QUESTIONS.

>> ALL RIGHT.  
GREAT. THANKS.

>> ALL RIGHT. THANK  
YOU VERY MUCH.