



**CMS 2011 MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN**  
**SPRING CONFERENCE**  
APRIL 12-13, 2011 | MARRIOTT HUNT VALLEY INN | BALTIMORE, MD

## **TRANSCRIPT**

**Susan Radke**

**Division of Medicare Advantage Operations, Medicare Drug and Health Plan Contract Administration Group  
CMS**

**LaVern Baty**

**Division of Medicare  
Advantage Operations  
CMS**

Susan: Good morning, and it's almost afternoon, and I know you're probably very anxious to get something to eat and to get warm, so we'll try to go as fast as possible. What I would like to do is first click on the screen. There we go. I would like to introduce to you myself., I'm Susan Radke, and I am the special needs plan team lead. We have a variety of folks on our team. LaVern Baty is one of our team members, along with Eric Nevins, Merv John, Barbara Bullock, and Melissa Staud, and Caroline Ferrell. We are led through Deanna Green, who is our acting manager right now.

And so we are very happy to have this time with you to talk about how to engage with your state in developing contracts with dual-eligible special needs plans. I also wanted to introduce to you our contractors for Booz Allen Hamilton, which is Jason Milstein and Pria Goldcourt, and they are working with us. We're having a great time working together to work on this contract task.

The purpose of this contract task is to support state Medicaid agencies in negotiating awarding contracts with dual-eligible special needs plans that offer both Medicare and Medicaid services in an integrated matter. We are trying to work through the use of the State Resource website, as well as a variety of other modalities.

As you know, in Section 164 of MIPPA, it mandates that the secretary of Health and Human Services provide the appropriate staff and resources to address inquiries from states regarding coordination of state and federal policies relating to special needs plans. So MIPPA has required us at CMS to implement a State Resource Center to provide technical assistance to state governments.

The Affordable Care Act requires that all dual-eligible SNPs have a contract with their state Medicaid agency in 2013. So through this contract with Booz Allen Hamilton, we are trying to meet this MIPPA and ACA mandates to provide technical assistance to states so they can get ready to assure that they have their contracts ready by 2013.

This requirement was designed to promote and encourage partnerships between SNPs and states so that we could better integrate Medicare and Medicaid for our dual-eligible beneficiaries, and, again, in Section 164 MIPPA required that new and expanding D-SNPs contract with state Medicaid agencies in the jurisdictions with which they operate. So I am going to hand this over to LaVern, who will be speaking specifically about the state Medicaid Agency contract requirements. I just want to make sure I'm on the right -- there we go. So LaVern, I'm going to take it over to you.

## **CMS 2011 Medicare Advantage And Prescription Drug Plan**

Lavern: Thank you, Susan. Susan introduced SNPs, the background, and the State Resource Center, and you probably got a sense of the dynamic nature of special needs plans. It's been extremely exciting working in this area because not only are we serving the poorest and the most vulnerable population but we have enjoyed the commitment of Congress to serve this population. I'm going to go back just a little bit, and I just wanted to speak a little bit about the bullet where it talks about the contracts between the MAOs that provide D-SNPs and the state Medicaid agencies; that they can only cover the jurisdictions that the eligibility categories and the populations that the state Medicaid agencies cover.

In other words, if an existing SNP that required a contract with the state Medicaid agency, because it was expanding, it can only cover those service areas that the state covers. Likewise, if this same SNP provided services to all duals in a given area, but now they are entering into a contract where the state provided services, let's say to individuals that are 65 and above only, the SNP would have to modify this contract. They would modify their SNP so that it only covered those 65.

Section 3205 of the Affordable Care Act extended the provision of Section 164 of MIPPA, such that certain SNPs may now operate without a contract through December 31st, 2012, and these SNPs that were new or expanded after MIPPA must have a contract with the state Medicaid agencies in which their plans operate. All these SNPs are required to have contracts to operate during contract year 2013.

In order to promote and encourage integration, MIPPA outlines eight elements that the contracts between the states and the MAOs that provide these SNPs that at a minimum include the following: Number one, the SNP's responsibility to provide or arrange for Medicaid benefits. And it's not that we want them to just document that. We'd actually like the contract to describe how it will either provide or arrange for those Medicaid benefits. Tell us -- let us know how you plan to do so. Number two, the contract should include the categories of eligibility for dual-eligible beneficiaries that may enroll in the SNP. And you have often heard the various terms that sounds like a really funny alphabet soup: WMB, SLMB, QMB+, and QI-1, and QDWI, those are the various eligibility categories that often the states use to describe their population. Three, the Medicaid benefits covered under the SNP; four, the cost sharing protections covered under the SNP; five, the identification and sharing on Medicaid provider participation. Of course, this is key.

If Medicaid terminates, or a provider is no longer participating with Medicaid, of course the beneficiary must know that information, and we would like the SNP to know that information so that they would not be sending beneficiaries to providers that would not be able to provide services to them. Seven, the service area covered by the SNP. Oh, and I skipped a big one. I'm sorry. Let me go back to number six; the verification of enrollees eligibility for both Medicare and Medicaid, that's key.

One of the areas that we noticed about SNPs when SNPs originally began was that that process was not always clearly defined. We weren't always sure how the eligibility was being determined; thus, we weren't always sure whether the people were actually eligible for the program for which they enrolled. But like said earlier, we receive a lot of support from Congress, and so they have actually put this element in here, tell us how you verify the eligibility, both Medicaid and Medicare.

And now I can go back to seven, and I'll repeat it--the service area covered by the SNP--and lastly, the contract period for the SNP. CMS suggests that these SNPs maintain an ongoing relationship with the state Medicaid agencies, having jurisdiction over their service area. This is important as well, because states have indicated at times -- as we have one-on-one conversations with states, they have indicated that after they work with a plan to develop the contract and they were able to obtain the proper signatures and it was properly endorsed, that no further communication took place between that special-needs plan and the state Medicaid agency. They did not even realize that the contract had been approved at all. I don't know what happened, whether there was breakdown in communication, whether maybe they did not initially set up with frequency in which they would have contact. But whatever the case, the state Medicaid agencies sometimes felt quite out of the loop and wanted to have more interaction, more regular interaction with the Special Needs Program.

So plans may wish to consider including in the contract maybe a minimum level of frequency in which you will share information, and we're hoping, of courses, as one of the elements even, where it describes and talks about the sharing of provider information that there would be regular contract so that information such as this would be shared just so you

## CMS 2011 Medicare Advantage And Prescription Drug Plan

would have some idea of the areas that we have most commonly seen deficiencies and to just give you sort of -- you actually now have the heads up. You can sort of prepare your contracts as you move forward, building these areas up.

One of the things that we want to keep in mind about Special Needs Plans is that they should have characteristics and be able to provide benefit packages to beneficiaries that differ from regular MA plans. We know that you do. Help us to share that information and be able to document that information about your plans, that you really are different and that you really are serving a population that's different. We want to be able to showcase you so that areas that if we could see more write up, a better description, as contract element one. Often contracts do not clearly state how the SNP provide or range for the Medicaid benefits. They may make a statement but do not actually describe the process.

Contract element three; contract does not list the Medicaid benefits to be covered by the SNP. This is important because it's also a MIPPA mandate that there must be a written comprehensive statement provided for all prospective enrollees. So there should be some idea of what those Medicaid benefits actually are, even though they may change.

And then contract element six, the one that I almost missed before, there's been vague descriptions of the Medicaid eligibility verification process. As you know, we no longer have sort of the disproportionate share SNPs. We're moving into where the SNPs must be a hundred-percent eligible for each group that they're in. If you're chronic care, you have to meet one of the chronic care areas. If you are an institutional SNP, they must meet an institutional SNP. Well the same for the D-SNP. The dual SNPs, those beneficiaries must be eligible for both Medicare and Medicaid and we must be able to verify that.

Options for contracting: States and SNPs have flexibility in how to design their relationship with each other. They are not required to provide for a capitated arrangement; however I do want to say here that it's worth noting that with the passage of the ACA, capitation is a required element for the fully-integrated dual-eligible SNP. So you may want to begin to think about that. You may not be capitated at this time if you are an existing SNP now, but as you move forward. For example, states and SNPs can pursue a partially-integrated option whereby the D-SNP provides some level of wraparound Medicaid benefits. Under this arrangement, the state provides other Medicaid benefits directly or through its other state-arranged contracts, and I'm sure we'll hear more about this from Susan or our contractors, Jason and Pria. On our website that Susan will share more about, there's a paper that actually gives sort of descriptions of those various levels, so you actually can download that document.

Section 3205 of the Affordable Care Act defines for the first time fully-integrated dual-eligible SNPs and gives CMS the authority to make PACE frailty payments to plans that meet this definition. Under CMS's proposed definition, a FIDE SNP enrolls special needs individuals entitled to Medicaid; provides dually-eligible beneficiaries Medicaid and Medicare benefits under a single MCO; has a capitated contract with the state Medicaid agency for primary, acute, and long-term care; coordinates care through a aligned care management and specialty networks; and lastly, coordinates and integrating member tier materials.

I will now turn this back over to Susan, and she will share more about the technical assistance provided by our State Resource Center. Thank you.

Susan: I have to go to go (INAUDIBLE), because I'm so small here. That's what happens when you're five-two. Okay. I wanted to talk to you more about specifics in the State Resource Center and our contract with Booz Allen Hamilton.

CMS, of course, remains committed to encouraging dual-eligible SNPs, and in particular, the FIDE SNPs, the fully-integrated dual-eligible SNPs, as a way to integrate Medicare and Medicaid services to the dual-eligible beneficiaries, who can be the most vulnerable population in Medicare advantage programs.

The State Resource Center is a website, and we also have it at the center, that provides information on D-SNP contracting processing, reducing some resource burden for the states. The issue, of course, that you may experience as health plans is that you are trying to reach out to your state and saying this is what we plan to do or this is how our program is set up. And unfortunately, due to economic times, states are quite overburdened and may not have the

## **CMS 2011 Medicare Advantage And Prescription Drug Plan**

administrative resources to give you your full attention. That is a reason why we are trying to work more intensely on developing the State Resource Center.

Historically, the Resource Center provided technical assistance to states by outreach and education regarding D-SNP requirements, assessing states' most pressing needs, hosting teleconferences between CMS and states, developing and sharing contract options papers, developing and maintaining the State Resource Center website, and developing a state-specific Medicaid benefits summary table.

Our future tasks, we just met with Booz Allen Hamilton, and we have gone really into the weeds and are looking towards the future regarding changes with statutes, and we want to facilitate future knowledge sharing teleconferences with states, and we are hoping to attend as many conferences to provide outreach to states. We want to develop outreach materials for states, focusing on the benefits of contracting with D-SNPs, and, believe it or not, there are many.

I have had the wonderful opportunity as a project officer, working on these dual-eligible programs and demonstrations, and I can tell you that being on site visits and visiting with dual-eligible beneficiaries and watching case managers talk to them about their Medicare and their Medicaid benefits, coordinate between their primary care physician and their specialists, making sure that they were not taking too much medication or were overly medicated, working on quality assurance issues--it works. These programs really do work, and we understand that they work. So we're really trying to encourage states to contract with you. We also want to provide ad hoc technical assistance and update and enhance the website.

We are now commencing with knowledge-sharing forums, and we are sponsoring quarterly teleconferences, and we're hoping to resume our conference in late April, where we have a task for that, so we're working hard on getting that call set up. We, during these forums, will, of course, discuss the latest statutory and regulatory trends. We'll solicit topics and concerns for future calls. We'll post summaries on the State Resource Center website. We are hoping to host sessions at upcoming conferences and furnish outreach materials that will specifically describe the benefits of contracting with your organizations.

Like I said before, our outreach materials will be designed to encourage states to contract with you, promote the benefits of D-SNPs, identify available resources to help states in the contracting process, and encourage states and the health plans to collaborate with each other.

We also are going to focus a lot of energy on redesigning the website. The website is a little bit outdated, and it's because we have been on hold. We've needed to have our regulations finalized before we could provide any guidance on that website. So we're going to update the organizational structure. We are going to add new subsections. We will update state-specific Medicaid benefits Matrix, which I'm glad to say has been accomplished. Now we just need to get it on the web. We are going to develop new content linked to other CMS resources and continually update the content to reflect the most up-to-date statutory and regulatory changes in guidance.

Also, through our contractor, we'll be providing ad hoc technical assistance via the State Resource Center email box. CMS will provide responses through one-on-one teleconferences or via email regarding, you know, what comes into the mail box. We also publish how-to guides and we're going to be updating those how-to guides with common questions on the State Resource Center website.

We wanted to let you know that we want to be able to update the Resource Center and provide you with information regarding how a fully-integrated dual-eligible SNP works, as well as provide you with a range of possibilities in contracting for your D-SNP. Not everyone is able to, in their state, to specifically target for full integration. Every state and every D-SNP has their own way of operating. So we hopefully provide you with a variety of information to the stage that you're in.

We also want to let you know that you too can remind state officials that the State Resource Center is available to provide them with resources on how to contract with your health plan. The website reference documents are available at this site. And if you have any specific questions, you can also go into that site, and our contractor will forward everything to us, and we can respond to you.

## CMS 2011 Medicare Advantage And Prescription Drug Plan

We are able to – I think we do have some time, believe it or not, so we can have some time for questions and answers. I just want to preface that we realize that right now we are in an application process and we are in a review process, and at this time, we cannot specifically answer any questions regarding your application or your contract process right now as it stands. But we can, you know, answer any questions regarding, you know, how to contact a state, anything about the State Resource Center at this time.

Jill: Okay. This time we're good at this. Raise your hand. You have a question over here, okay.

Audience Question: Thank you. We're very excited to see this. We have had a really challenging time here. We are not a fully-integrated dual SNP. So if I understand your presentation today, there's going to be assistance for those of us who haven't – don't have a fully-integrated dual to be able to work with the states because they have no way to respond to us today. We've made monthly, weekly attempts to try to communicate. So forthcoming, you'll give us that guidance and we can reach out directly to you for assistance or how does this – how do we utilize these resources?

Panelist: Go ahead. It will. Just talk. [Pause.] What we're hoping is that you could send any concerns or information to us via the website. Our contractor will get with us. We will be having – like I said, we're going to be having phone calls and sharing forums with states so that what we could do is we could connect you – we could help you and assist you and connect you with your state so you can begin that dialogue process.

Jill: Wonderful. We have a question over here.

Audience Question: Yeah, hi.

Jill: Right here.

Audience Question: Yeah, hi. Just a few questions, if I can ask. One is, are you guys proactive with this in reaching out to states? Because one of the things that I've seen is they're not really aware of the requirements that need to be in the contract, and as much as we educate them, they're still hesitant, and they kind of have their own views on what needs to be in there. And the second piece is, have you thought of any cures for states that want to do contracts for fiscal year versus calendar year? Because I know the requirement is January 1 until December 31st. Some states like to do July to July or June to June.

Panelist: Okay. I can have Jason talk about the first question.

Jason: Sure. So we realize that MIPPA did not mandate that the states have to contract with the Medicare Advantage organizations, so what we see our role as is providing another avenue to educate the states with CMS's backing of the regulations. So if there's any concerns about the MAO saying something that may not be accurate that the state might have, that they can also get the same guidance from the State Resource Center.

What we are planning on doing is sending a letter to the State Medicaid Directors letting them know that the knowledge-sharing forms exist and seeing if they want to continue to participate. Unfortunately, as I said, there is no requirement that they do contract, so it's really just our best efforts to get them to interact with us.

Audience Question: States that do want a contract and that have had discussions with plans, they just aren't aware of the requirements, or we give them the guidance and they're just not 100% sure what needs to be in there, should we be sending them to you all or are you guys reaching out to them at that point in time?

Panelist: Sure. In that situation we would recommend that you direct them to the State Resource Center website and the associated email address. And if you have any concerns, you can also email us directly and we can try and reach out to them as well. We aren't doing anything proactive without prompting, I guess, would be the right way to put it.

## CMS 2011 Medicare Advantage And Prescription Drug Plan

And just so that you're aware, MIPPA actually did not require the states to have to enter into a contract with the special needs plans. States actually, not only did not have to enter into a contract, MIPPA did not require that of them, they also can select which plans they may wish to enter into a contract with versus those they did not. For example, if there are five different special needs plans in their area and all five of them wish a contract, but they are only interested in entering into a contract with two of them, they actually have that ability to do so. That's one thing that you should be aware of – be made aware of.

Okay. Secondly, your question about the contract period, that the Medicare has requested a calendar year, January 1 through December 31st, and as you know many of the states, their contract years may be on the fiscal year that starts July 1 through June 30t. That's one of the reasons that we are very much aware of that, and we've worked with the plans to handle that process by extending at times the year, various methods we've used to sort of informally handle that as we attempt to come up with a procedure that would take care of it all together.

One of the things that we did invite your comments on in the call letter was having a February submission of the contracts in an attempt, again, to put those two sets of contract times on the same playing field. Well, we haven't received a very positive response about that one, but we are working on that. We are working on that. And to the degree that we're able to talk with the plans as well as the states, we have invited one-on-one conversations so you can submit your comments to the mailbox, and we've talked to both of you at the same time to see whether there were ways we could handle the difference in time schedules. We do recognize it though.

Jill: Good. Question right here, please.

Audience Question: I'm [Audience Name Withheld], and I have two recommendations and one question, and these relate to the first two questions. Recommendation number one, while I think everybody is aware you can't force a state to contract, and it is quite comforting to see your goals being more proactive, I actually recommend that if a SNP is getting absolutely no contact with a state, that they're not responding, that if the SNP actually asks you to call somebody in the state at least once to establish – to say, "We're available, we can help you," I think something like that potentially could be a lot more constructive than sending a letter to a state Medicaid director.

My second recommendation, and I know this has been asked several times, it would be helpful to post on the Resource Center a series of state contracts that you have approved, bearing in mind that you're not necessarily recommending one form versus another, but that would be particularly helpful as well.

My question is, at least as of two months ago, on the website there was the CMS guidance related to state contracting requirements, and I believe that was written at the end of 2009, if I'm not mistaken, are there plans to update that? That's my question.

Panelist: Sure. So in regards to your question, that's actually one of our major tasks that we're gearing up for right now is to look at all of the content that's currently on the website, ensure that everything is accurate, and then try to move forward to creating a website that really provides a soup-to-nuts type of explanation as to what SNPs are, what Medicare is. Some of the feedback that we've heard from states is that they're very apprehensive about contracting they just don't understand Medicare at all. They understand their Medicaid piece, but don't really understand how that fits in. So trying to provide links back to explanations about Medicare, about the plans, the history, the requirements, and then also moving into a direction where there's very specific details of regulations and guidance for the states that have been in the process that understand all the basics, we'll want to make sure that they are up-to-date. So, yes, we are definitely looking at all the content on the website and we'll make changes as appropriate.

Jill: Good. We have a question right here.

Audience Question: Hello. I'm [Audience Name Withheld] from Health First in New York. We had a question related to the definition of fully-integrated SNP plans. Is it that if you have a capitated arrangement that qualifies as fully-integrated, but if it's wraparound, that's not considered fully-integrated? Are those two separate distinctions?

## CMS 2011 Medicare Advantage And Prescription Drug Plan

Panelist: The definition includes capitated. You may also have wraparound as one of the elements in it, but to me, all of the elements of that definition would actually have to supply all of the elements that are listed in the regulations.

Audience Question: Okay. And a second question was related to if you have more than one type of SNP plan, do you need a separate contract for each of those SNP plans? Even if it's a fully-integrated SNP, do you still need a separate MIPPA contract?

Yes, you do?

Panelist: Well, actually, what's making us sort of hesitate is the way we use the term "contract" is around the Medicare Advantage organization itself, and so then it has the various SNP. We call them "PBPs," the Plan Benefit Packages. But if there's a different type, if you have one that's fully-integrated, the other one is zero cause, yes, you would need separate PBPs for those.

Audience Question: Okay.

Panelist: They may have the same H contract number, but they would have a different PBP. And if I could, I would like to also sort of speak to Mark Joffy's recommendation. Thank you, Mark, for that recommendation about posting various contracts. We've thought about that – and do I want to (INAUDIBLE) teleconferences is they come up, we could discuss that. But generally, the states have not been very agreeable to having their actual individual contracts up. Some of the information that's in there is proprietary, some of it is financial disclosure that they're not allowed to put in there. And they weren't very receptive to, you know, trying to cross that information out and then posting it on the website. But what they did do – what they very much decided they would do and were very agreeable to was during the last two sharing teleconferences, several of them, I think, Pria, it's been as many as 29 different states, I can't recall how many states.

Panelist: 29, I think it is.

Panelist: They volunteered to actually put their contact information and submit it so that they could share that information directly. So those states that volunteered to do so, we send the list to them. They're able to contact the state during the sharing teleconference, maybe that state sounds similar to them, and they could call that state directly and say, "Do you mind sharing your contract with me?," and they would say "sure," and they could sign it. If not, they have to ask – come through us, we have to get the permission first. But this way they could talk to one another directly.