Common D-SNP Contracting Issues and Discussion

Revised September 2011

I. Background and Purpose

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (as amended by the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010) included new opportunities to improve the integration of Medicare and Medicaid benefits for dually eligible beneficiaries by requiring Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs) to obtain contracts with State Medicaid Agencies. CMS' implementing regulations enumerated eight elements that those contracts must contain[1].

MA organizations offering new D-SNPs, or seeking to expand the service areas of existing D-SNPs (or change their SNP type), must enter into contractual relationships with States "to provide benefits, or arrange for benefits to be provided, for which [an] individual is entitled to receive as medical assistance under Title XIX." Currently, Federal law requires all *new* D-SNPs to obtain a contract with the State Medicaid Agency and all existing D-SNPs to obtain a contract starting with Plan Year 2013 (existing D-SNPs that do not change D-SNP type or request a service area expansion can continue operating without a State contract through December 2012).

In 2013, all MA organizations seeking to offer a D-SNP must execute a contract with the State Medicaid Agency in the state(s) it wants to offer the plan(s). To assist State Medicaid agencies in improving benefit integration through D-SNPs, CMS has established a State Resource Center to equip States with helpful information as they engage in contract negotiations with MA organizations and provide additional information regarding the Medicare and MA program. CMS created this "Contracting Issues and Discussion" document to address frequently encountered concerns and provide guidance to States regarding State/MA organization contracting requirements, Affordable Care Act 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 D-SNPs are required to have a contract with the State?

For Plan Year 2013, Federal law requires all MA organizations to obtain a contract with the State Medicaid Agency. For Plan Year 2012, MA organizations seeking to offer new D-SNPs or seeking service area expansions for their existing D-SNPs or to change D-SNP type are required to have contracts with the appropriate State Medicaid Agencies. Existing D-SNPs that are not expanding their service areas and

[1] For additional information on the eight contract requirements, please see: *MIPPA State Contracting Options*, available at: http://www.cms.gov/SpecialNeedsPlans/Downloads/MIPPA_State_Contracting_Options_010410.pdf.

do not wish to change D-SNP types may continue to operate without a State contract and have until December 31, 2012 to establish a contract with the appropriate State Medicaid Agency(ies) to offer the plan during Plan Year 2013.

2. Is it the State's responsibility to initiate a D-SNP contract?
   No, this is not the State's responsibility. The MA organization should approach the State if it wants to contract with a D-SNP operating in the State. As of Contract Year 2013, all D-SNPs are required to have contracts with the States in which they operate.

3. Must State Medicaid agencies contract with an MA organization?
   No, Congress did not mandate that States contract with an MA organization for a D-SNP. It is up to the MA organization 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. That said, CMS has encouraged the proliferation of D-SNPs in its Medicare-Medicaid benefit integration strategy.

4. If States wish to enter into D-SNP contracts with some MA organizations, must the State contract with every interested MA organization?
   No, States are not required to contract with any MA organization and may be selective about those with whom they choose to contract. In other words, if more than one MA organization offers a D-SNP in your state, the State may choose to contract with each of them, one of them, or none of them.

5. Who is responsible for providing the care management services mandated by MIPPA?
   Any MA organization offering a SNP 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. Starting for Plan Year 2012, pursuant to an Affordable Care Act mandate, the National Committee for Quality Assurance (NCQA) began reviewing and approving all SNPs', including D-SNPs', Models of Care. Nonetheless, States are responsible for monitoring the MA organization's adherence to the State/D-SNP contract.

6. Are States responsible for reviewing the D-SNP Summary of Benefits?
   MIPPA Section 164(c)(3)(C) mandates that each D-SNP provide prospective enrollees, prior to enrollment, with a comprehensive written statement (using standardized content and format established by the Secretary) that describes: 1) the benefits and cost-sharing protections that the individual is entitled to under the State Medicaid program under title XIX; and 2) which of such benefits and cost-sharing protections the plan covers. CMS is ultimately responsible for approving each Summary of Benefits document. The CMS Division of Medicare Advantage

Operations 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 D-SNPs, one with an approved contract with the State Medicaid Agency but the other without a contract, consolidate the two D-SNPs under the D-SNP with the approved contract?

   Not necessarily. With CMS approval, plans may opt to consolidate multiple plan benefit packages under one contract with CMS only where all of the D-SNPs under consideration for consolidation include the same eligibility criteria, For example, an MA organization that contracts with a State to offer a D-SNP that restricts enrollment to only full benefit dual eligible beneficiaries may not consolidate that D-SNP with a non-contracted D-SNP that enrolls all categories of dual eligible beneficiaries.

   For further guidance, please refer to the 2012 Call Letter (in the 2012 Announcement), available on CMS' website at: https://www.cms.gov/MedicareAdvtgSpecRateStats/AD/list.asp.

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 the MA organization provide?

   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 and CMS' implementing regulations, the contract must, at a minimum, describe the MA organization's responsibility to integrate and/or coordinate Medicare and Medicaid benefits. CMS will not accept an administrative services agreement (i.e., an agreement in which the contracted MA organization provides solely administrative functions such as claims processing) as meeting MIPPA requirements. As such, CMS requires States and MA organizations 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. Do the MA organization and State Medicaid Agency need to include remuneration in the contract?

   CMS does not require States 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 Affordable Care Act, fully integrated D-SNPs (FIDE SNPs) may receive alternative MA payments based on Program of All-Inclusive Care for the Elderly (PACE) payment rules. CMS promulgated a definition for FIDE SNPs in CMS-4144-F that states CMS considers a D-SNP to be a FIDE SNP if the plan provides dual eligible beneficiaries with access to Medicare and Medicaid benefits under a single managed care

organization and coordinates the delivery of covered Medicare and Medicaid health and long-term care services[2].

3. If the State chooses not to include a Medicaid service provision in the contract, do States still need to share Medicaid provider information?

   States that choose to negotiate and award contracts to MA organizations for D-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 D-SNP. The State is under no obligation to monitor the degree to which the MA organization incorporates Medicaid providers into its D-SNP provider directory. However, CMS encourages such an arrangement to facilitate a collaborative effort to provide services to dual eligible beneficiaries.

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

   If the D-SNP service area covers multiple States, MA organizations are required to submit a fully executed contract with each associated State for CMS review. CMS defines a "fully executed contract" as 1) being signed by the MA organization and the State Medicaid Agency; 2) including all eight required elements[3]; 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. The MA Application includes the Contract Matrix, which allows MA organizations to document how their contract with a State meets the applicable MIPPA requirements.

5. Regarding the MIPPA requirement for a D-SNP to "provide or arrange" for Medicaid services, does directing the beneficiary to call his or her Medicaid managed care organization qualify?

   CMS recognizes that in limited circumstances, dual eligible beneficiaries may receive all Medicaid benefits through a Medicaid managed care contractor that is a separate organization from the MA organization offering the D-SNP. In these cases, the D-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 by the D-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 to which they are entitled. Consequently, directing enrollees to call their Medicaid MCO or to a website will not sufficiently meet the coordination threshold.

---

[2] 42 CFR §422.2

[3] CMS identified the eight elements in a July 17, 2009 Health Plan Management System (HPMS) memo. The HPMS memo (titled: *SNPs_HPMS_DE_ContractElements07-17-09.pdf*) is available at: http://www.cms.gov/SpecialNeedsPlans/Downloads/SNPs_HPMS_DE_ContractElemnts07-17-09.pdf

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

   CMS anticipates that the integration or coordination of benefits 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 Affordable Care Act, the goal is increased integration and coordination of Medicare and Medicaid services/benefits for dual eligible beneficiaries. Also, D-SNPs, under their Medicare contract, are required to meet the needs of their populations by providing appropriate care. This includes such things as an evidence based model of care, specialized provider network, risk assessments for beneficiaries, and use of interdisciplinary teams.

7. Should the MA organization 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 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 D-SNP to verify an enrollee's Medicaid eligibility status. Also, States should share information with the D-SNP to identify which providers accept Medicaid. The D-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 the significant variability in Medicaid program designs and States' experiences in collaborating with MA 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 contracting requirements. This document is available on the State Resource Center website (http://www.cms.gov/SpecialNeedsPlans/05_StateResourceCenter.asp). In addition, CMS includes a contract matrix in its MA application (available at: https://www.cms.gov/medicareadvantageapps/) the MA organization must complete to identify how its contract with the State meets the State/MA organization contracting requirements. Also, see question Number 10, below.

10. How can less experienced States learn from more experienced States on D-SNP contracting issues?

    Several States have expressed interest in contacting other States directly to collaborate on D-SNP contracting issues. To assist States with this endeavor and foster collaboration, CMS has developed a shared State contact list, which is available by request from 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. Currently, CMS will only furnish this list to interested State Medicaid officials that have also volunteered to participate on the list. MA organizations and other interested parties can contact their Regional Account Manager or the State Resource Center for additional assistance.

IV. SNP Requirements

1. How are quality of care reporting requirements different for SNPs?

While CMS requires all MA plans to report Health Plan Employer Data and Information Set (HEDIS) performance measures, CMS also requires SNPs to report two distinct HEDIS measures. 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. CMS requires SNPs to report both HEDIS and Structure and Process measures. Additional information may be found at: http://www.cms.hhs.gov/SpecialNeedsPlans/. Moreover, the Affordable Care Act requires that, beginning in 2012, NCQA approve all SNPs based on standards established by the Secretary. CMS announced these standards in April 2011. Beginning with Contract Year 2012, all SNPs need to include a Model of Care (MOC) in their applications that consists of eleven clinical and non-clinical elements. The MOC should show how the SNP will address the specific needs of the target population. Additional information on the NCQA approval process and scoring criteria may be found in the CMS *Special Needs Plan Approval Process Scoring Criteria for Contract Year 2012* (dated April 5, 2011, http://www.cms.gov/SpecialNeedsPlans/Downloads/CY2012_NCQA_SNP_Approval_Guidance.zip).

2. Do any D-SNP-specific quality reporting requirements exist?

No. While there are SNP-only measures (both HEDIS and Structure and Process), these are required of all SNPs, not just D-SNPs. As described above, the Affordable Care Act also requires SNPs to include a MOC in their applications. Although there are no MOC elements specific only to D-SNPs, they should show in the MOC how the D-SNP will meet the clinical and non-clinical needs of their dually eligible enrollees.

3. Must all MA organizations that enroll dual eligible beneficiaries be designated as a D-SNP?

No, MA organizations that do not operate D-SNPs may still enroll dual eligible beneficiaries. In general, CMS requires that MA plans accept *all* Medicare beneficiaries (excluding individuals with End State Renal Disease who receive their diagnosis prior to their initial enrollment request into MA), including dual eligibles. Congress created Special Needs Plans so that individuals with specified demographic factors or medical conditions could receive benefits targeted to their unique needs. D-SNPs, a subset of Special Needs Plans, tailor their benefits to meet the needs of the dual eligible population and can only enrollee dual eligible beneficiaries. Each dual eligible beneficiary can determine whether a regular MA plan or a D-SNP is most appropriate to meet his/her needs.

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

In order to offer an MA plan (including a D-SNP), the sponsoring MA organization must provide, at minimum, all Medicare benefits the enrollees would be entitled to under Original (fee-for-service) Medicare. MA organizations typically provide additional benefits not available under Original Medicare and these benefits must be submitted to CMS as part of the MA bid process and approved before they may be offered to enrollees.

States can negotiate with MA organizations to influence what supplemental Medicare benefits the D-SNP will cover. This is an area where States can realize savings from integration—they can negotiate with the MA organization to have a D-SNP cover some Medicaid services, such as vision and dental, for example, as supplemental *Medicare* benefits. As MA 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 it can cover as supplemental Medicare benefits for each plan year.