Centers for Medicare & Medicaid Services

State Resource Center

# State Options for Designing Dual SNP Contracts with Medicare Advantage Organizations that Adhere to MIPPA Requirements

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# State Resource Center: State Options for Designing Dual SNP Contracts with Medicare Advantage Organizations that Adhere to MIPPA Requirements

*Note: This is a resource document providing options to States for their consideration as they contract with Medicare Advantage (MA) Organizations offering new dual eligible Special Needs Plans (Dual SNPs) or expanding the service areas of existing Dual SNPs. All contracting arrangements between a State and an MA organization must satisfy the requirements in CMS regulations and guidance. This document in no way establishes requirements for States in contracting with MA organizations for Dual SNPs.*

The enactment of the Medicare Modernization Act (MMA) in 2003 introduced a new type of coordinated care health plan, the Special Needs Plan (SNP), into the Medicare Advantage program. SNPs are unique in that they can target enrollment to "special needs" beneficiaries identified as: (1) institutionalized beneficiaries, (2) beneficiaries with severe or disabling chronic conditions, and (3) beneficiaries who are dually eligible for Medicare and Medicaid (dual eligibles). Through improved coordination and continuity of care, SNPs provide an opportunity to improve care for these targeted groups. In particular, SNPs that target dual eligibles (Dual SNPs) provide a unique opportunity to provide better coordination and integration of care for dual eligible beneficiaries by offering a full array of Medicare and Medicaid benefits. However, the proliferation of Dual SNPs has illuminated the challenges States, the Centers for Medicare & Medicaid Services (CMS) and Medicare Advantage (MA) organizations jointly face in effectively sharing information and integrating benefits. The enactment of the Medicare Improvements for Patients and Providers Act (MIPPA) in July 2008, as well as the promulgation of subsequent regulations, reflect an effort to improve Medicare-Medicaid benefit integration by mandating that, effective January 1, 2010, MA organizations offering new Dual SNPs, or seeking to expand the service areas of existing Dual SNPs, enter into contractual relationships with States. Specifically, MIPPA Section 164 requires that all MA organizations have "a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy." The regulations authorizing contracting requirements (42 CFR § 422.107) have provided some additional guidance on this requirement; specifically, that MA organizations offering new Dual SNPs or seeking to expand the service areas of their existing Dual SNPs must have a contract with a State Medicaid agency for the 2010 plan year that documents, at minimum:

- The MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits;
- The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under the Statute at sections 1902(a), 1902(f), 1902(p), and 1905;
- The Medicaid benefits covered under the SNP;
- The cost-sharing protections covered under the SNP;
- The identification and sharing of information on Medicaid provider participation;
- The verification of enrollee's eligibility for both Medicare and Medicaid;
- The service area covered by the SNP; and
- The contract period for the SNP.

To address State inquiries with respect to the coordination of State and Federal policies for Dual SNPs, CMS is establishing a State Resource Center to provide States with helpful information to enable the successful negotiation and award of contracts to these plans, as well as to assist States in improving the coordination of Medicare and Medicaid processes. Booz Allen Hamilton (Booz Allen) is supporting CMS in the creation of the State Resource Center and, in response to several inquiries from States regarding the MIPPA contracting rules, has developed a series of contracting options specific to the MIPPA requirements that States may wish to consider when developing MIPPA-compliant Dual SNP contracts. These options are based upon Booz Allen's review of several historical and existing contract documents between States and Medicaid managed care organizations; interviews with State Medicaid agency officials, CMS experts, health plan officials and advocacy groups; as well as a literature review. While the options expressed in this paper do not reflect an exhaustive list of all possible paths a State may follow in creating a MIPPA-compliant contract, the options are intended to provide States with a framework for moving forward in the contracting process. States are encouraged to work closely with MA organizations (with CMS as a secondary resource) during contract development to ensure that a final contract meets CMS' contracting requirements. The *2010 Call Letter* (see Appendix C) requires that any MA organization offering a new Dual SNP, or seeking to expand the service area of an existing Dual SNP, has a signed contract with the respective Medicaid State agency by October 1, 2009 as a pre-condition of contract award from CMS. Please note that, per MIPPA statute, States are not required to enter into a contract with an MA organization for a Dual SNP. In addition, please note that MA organizations offering Dual SNPs are required to meet all applicable Medicare Advantage program requirements regardless of their contractual relationship with a State.

In discussing the State contracting options for Dual SNPs, it is important to understand and identify the Title XIX services States must provide for Medicaid beneficiaries, particularly since Medicare covers some of these services and is the primary payer on all services covered by both programs. Unless waived under Section 1115 of the Social Security Act, State Medicaid plans are required to cover a core set of services for those who are categorically eligible for Medicaid benefits. The full list of mandatory benefits can be found in Appendix B. Listed below are the services most likely to benefit dual eligibles.

- Inpatient hospital (excluding inpatient services in institutions for mental disease)
- Outpatient hospital
- Other laboratory and x-ray
- Nursing facility services
- Physicians' services
- Medical and surgical services of a dentist
- Home health services for beneficiaries who are entitled to nursing facility services under the State's Medicaid plan

Additional services may be provided in States who opt to include "medically needy" individuals under their Medicaid plans, or who use a waiver to expand covered benefits. For some individuals dually eligible for Medicare and Medicaid, known as Qualified Medicare Beneficiaries (QMBs), Medicaid pays the dual eligible's Medicare premiums, deductibles and

coinsurance. Medicaid covers other Medicare costs for individuals in other dual eligible categories; please refer to Appendix B for details. Information on the various authorities available to States that may be utilized in the development of integrated care programs is available in the "*At-A-Glance" Guide to Medicaid Authorities for Integrated Programs* on the CMS website.[1]

Lastly, it should be noted that MA organizations are bound by CMS contracting timeline requirements. These requirements, expressed in the table below, affect when a State and an MA organization may negotiate on benefits as well as when contracts between States and MA organizations must be finalized and effectuated.

| Date | Associated Deadline/Event |
|---|---|
| May 15, 2009 | CMS begins accepting CY 2010 bids via HPMS |
| June 1, 2009 | Deadline for submission of CY 2010 bids for all Medicare Advantage applicants, including Dual SNPs |
| Late August/Early September 2009 | CMS completes review and approval of 2010 bid data |
| October 1, 2009 | Finalized 2010 State Medicaid agency-MA organization contracts due to CMS (only for new Dual SNPs or existing Dual SNPs seeking to expand their service areas) |
| January 1, 2010 | Contracts between Dual SNPs and State Medicaid agencies must be in effect |

## MIPPA Requirements and State Options

The following sections present the eight contracting requirements put forth under MIPPA as well as various options States may wish to adopt in order to meet these requirements.

### MIPPA Requirement 1: The contract must document the MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits

Although not reflective of all possible State arrangements for providing Medicaid benefits to dual eligibles, a review of existing integrated contracts between States and organizations providing Medicaid managed care plans in concurrence with a Dual SNP revealed a significant amount of variability regarding the scope of Medicaid benefits provided or arranged for by the SNP. This variability is to be expected, as States and MA organizations can develop agreements for Dual SNPs to assume responsibility for providing or arranging for a wide range of Medicaid services based on each State's ability and interest in integrating its Medicaid program with Medicare via a SNP, as well as the dual eligible subset population the State may choose to target.

As States and MA organizations move forward in the contract negotiation process and make determinations of the MA organization's Medicaid benefit responsibilities, it must be noted that contracts limiting the MA organization's responsibilities to administrative services (e.g. cost-sharing, data-sharing) or care coordination services will not sufficiently meet MIPPA's contracting requirements. While all contracts must specify that the Dual SNP is responsible for

[1] This document is available as a download from the Integrated Care Roadmap on the CMS website at: http://www.cms.hhs.gov/IntegratedCareInt/2_Integrated_Care_Roadmap.asp

member-directed care coordination of both Medicaid and Medicare services, CMS has also determined that all contracts must also provide or arrange for some level of value. This type of arrangement may involve a payment from the State to the MA organization to provide benefits, though CMS does not require it during the 2010 contract year.

## MIPPA Requirement 2: The contract must document the category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP

As several different categories of individuals can be determined to be dually eligible for Medicare and Medicaid benefits, it is important that the contract between the MA organization and the State Medicaid agency clearly documents which category(ies) of dual eligibles may be enrolled in the SNP. As stated in the *2010 Call Letter*, any Dual SNP with a State contract (i.e., a "Medicaid subset" SNP) must enroll "the Medicaid population identified in the executed State Medicaid Agency contract as the target population." In essence, an MA organization may not impose more restrictive or expansive Medicaid eligibility requirements for enrollment into the SNP than the State imposes for enrollment into the Medicaid program, unless agreed to by the State under the contract.

In order to be compliant with MIPPA requirements, any contract between a State and an MA organization must detail categories of Medicaid eligibility for enrollment into the SNP. For example, a 2008 model contract for Virginia's Acute and Long-Term Care Services (VALTC) managed care program contains language that successfully meets this MIPPA requirement. This contract specifies that, in order to be eligible for the program, individuals need to be "existing and newly enrolled full benefit dual eligibles: individuals enrolled in Medicare and eligible for Medicaid coverage. These participants are included in the Virginia Administrative Code as 'Qualified Medicare Beneficiaries (QMB) Plus.'" The contract also describes individuals who are not eligible for the managed care program as follows: "This program also will not include 'non' full benefit dual eligibles [commonly referred to as partial duals] such as: Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), or Qualified Individuals (QI)." Please refer to Appendix A for specific contract language.

## MIPPA Requirement 3: The contract must document the Medicaid benefits covered under the SNP

As expressed in MIPPA Requirement 1 (requiring the contract to document the MA organization's responsibility to provide or arrange for Medicaid benefits), State contracts for Dual SNPs are likely to vary widely in the scope of covered Medicaid benefits. Requirement 3 accounts for this variability by requiring that the contract include information on benefit design and administration related to all Medicaid benefits covered under the SNP as well as document the benefits for which the MA organization is responsible for providing or arranging. If the list of services is an attachment, it must be referenced in the body of the contract per the July 17, 2009 HPMS memo. As the party responsible for providing care coordination, the Dual SNP needs to be fully aware of all the services entitled to its dually eligible enrollees as well as the party responsible for covering each service. This knowledge is essential to the Dual SNP's

ability to coordinate the member's benefits and prevent overlapping services. Possible scenarios include:

- Service covered under the Dual SNP through Medicaid capitation
- Service covered under the Dual SNP through Medicare capitation (includes mandatory supplemental benefits [2])
- Service covered under fee-for-service Medicaid
- Service covered under Medicaid through other State-arranged contracts (e.g. home and community-based waiver services or other carve-out services such as behavioral health)

As an MA organization must enter into separate contracts for the Dual SNP – one contract with CMS for providing Medicare benefits and another contract with the State Medicaid agency for providing Medicaid benefits – States may utilize this opportunity to influence the composition of the benefits covered under *both* of the Dual SNP contracts. In doing so, States may choose to negotiate with the MA organization to cover certain Medicaid benefits under the organization's Medicare Advantage contract with CMS, provided that the benefits in question are allowable under Medicare.[3] New York, for example, has negotiated with MA organizations to provide routine hearing and vision care services – Medicaid benefits in the State – through the organizations' Medicare Advantage contracts with CMS. It should be noted that any benefits arrangements between States and MA organizations cannot require a Medicare bid change after the first Monday in June, when all MA organizations must submit their bids to CMS. Contracts between States and MA organizations cannot exclude any Medicare benefits included in the MA organization's bid submitted to CMS, or provide for additional Medicare benefits not included in the MA organization's bid.

Should a State and an MA organization agree to cover some Medicaid benefits under the MA organization's contract with CMS, the Medicaid benefits in question would be structured as mandatory supplemental benefits. If these Medicaid services provided under the CMS contract are not equal to or greater than the benefit required in the Medicaid State plan, other arrangements will need to be made to ensure that enrollees receive the Medicaid services for which they are entitled. If a State chooses to enter into this type of arrangement, then the financial responsibility for these Medicaid benefits must be expressed in the contract, i.e., the contract must express if these services are to be paid for by Medicare or Medicaid. In addition to negotiating with a SNP to cover additional Medicare-covered services, i.e., mandatory supplemental services, a State can negotiate with the SNP to provide supplemental benefits paid for by Medicaid.

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[2] "Mandatory supplemental benefits" are benefits available to all enrollees in an MA plan and are paid for by premiums and cost-sharing or, most likely in the case of a Dual SNP, by rebate dollars. MA organizations are permitted to retain 75 percent of rebate dollars (the difference between the CMS benchmark and the lower amount bid by the MA organization for its package of all Medicare services), and must apply these dollars to reduce premiums and cost-sharing or provide additional benefits. Any supplemental benefits funded by rebate dollars must be directly health related and not covered by Medicare (e.g., vision, dental benefits). Please refer to the *Medicare Advantage Rate Setting and Risk Adjustment* primer published by the Center for Health Care Strategies, Inc. (link at http://www.cms.hhs.gov/IntegratedCareInt/2_Integrated_Care_Roadmap.asp#TopOfPage) for more information.
[3] Please refer to Chapter 4, Section 10.10 of the Medicare Managed Care Manual (http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf) for the definition of a "benefit" offered by an MA organization.

## MIPPA Requirement 4: The contract must document the cost-sharing protections covered under the SNP

MIPPA regulations require that all contracts between States and MA organizations include a provision documenting the cost-sharing protections that are covered under the SNP. These cost-sharing protections pertain to the protections for which enrollees are entitled to under Title XIX of the Social Security Act, including enrollee liability protections. In addition, MIPPA 165 requires that, as of January 1, 2010, a SNP may not subject any full-benefit dual eligible or qualified Medicare beneficiary[4] enrolled in the plan to any cost-sharing that exceeds the amount of cost-sharing that would be permitted under Title XIX if the beneficiary was not enrolled in the SNP. Documentation of all cost-sharing protections must be included in any contract between a State and an MA organization.

A review of several existing and historical contracts between States and Medicaid managed care organizations (some of whom also operate Dual SNPs) reveals little significant variation in State approaches for satisfying Title XIX requirements (all Medicaid managed care organizations have had to comply with Title XIX cost protections for several years). While these contracting documents do not fully address the additional cost-sharing requirements promulgated under MIPPA 165, the contracts do illustrate approaches that States may wish to adopt either singularly or in combination for satisfying MIPPA's cost-sharing protections requirements in a SNP contract. The following are two possible options for satisfying this requirement.

### Option 1: Include specific language on cost-sharing protections in the contract

It is recommended that States clearly describe the cost-sharing protections required of a Dual SNP in the contract. Several examples of explicit language pertaining to required Title XIX cost-sharing protections can be found in existing and historical contracts between States and Medicaid managed care organizations. Please refer to Appendix A for specific contract language, and note that these examples were created prior to the development of additional cost-sharing requirements contained in MIPPA 165. Examples include:

***Adherence to enrollment fees, premiums and other cost-sharing requirements.*** A review of existing contracts between States and Medicaid managed care organizations revealed little variability in how States craft language pertaining to premiums, deductibles and other cost-sharing protections contained in Title XIX.

- A 2003 Massachusetts contract notes that, because the plan is available only to full benefit dual eligibles, Medicare beneficiary premiums and cost-sharing requirements are waived. The contract also includes a provision stating that the contractor will not charge enrollees co-insurance, co-payments, deductibles or any other amount for any service provided under the contract.

[4] Please refer to Section 1905(p)(1) of the Social Security Act for a complete definition of a "qualified Medicare beneficiary."

- A 2009 Minnesota contract for providing integrated Medicaid and Medicare benefits notes that the contractor must ensure that providers not deny any covered services to an enrollee because of the enrollee's inability to pay a cost-sharing requirement. The contract also states that the contractor must not hold enrollees responsible for any charges or deductibles for medically necessary covered services or services provided as alternatives to covered services under the contractor's care management plan.

***Adherence to enrollee protections from liability requirements.*** Several recent contracts contain explicit language related to Section 1932 of Title XIX, which requires Medicaid managed care organizations to protect enrollees from being held liable for payments that are the responsibility of the managed care organization. For example:

- New Mexico's 2008 Coordinated Long-Term Services model contract includes a provision stating that enrollees will be "held harmless" against any liability for debts of the contracted organization.

- Virginia's 2008 Acute and Long-Term Care Services model contract explicitly states that, "pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6))", the contracted organization and any subcontractors must not hold an enrollee liable for 1) debts of the organization, 2) payment for services provided by the organization/subcontractor if the organization/subcontractor has not received payment from the State or the organization, and 3) any payments made for covered services to a provider that are in excess of the amount that the enrollee would have paid if the organization had provided the service directly.

- Wisconsin's 2007 Partnership Program model contract includes a provision requiring all subcontractors to ensure that providers do not hold enrollees liable for any costs that are the responsibility of the contracted organization per Title XIX requirements.

***Adherence to sanctions requirements.*** Per Section 1932 of Title XIX, a State may not enter into or renew a contract with a Medicaid managed care organization unless the State has established sanctions that can be imposed on the organization for "imposing premiums or charges on enrollees in excess of the premiums or charges permitted" under Title XIX. The following example reflects a common approach for meeting this requirement:

- New York's 2006 Medicaid Advantage model contract states that the contractor is subject to "local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program" for practices including "imposing premiums or charges on enrollees that are in excess of the premiums or charges permitted under the Medicaid Advantage program."

### Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements

Rather than articulate specific cost-sharing protections in the contract, States may wish to cite the requirements Dual SNPs must cover in order to be in compliance with all applicable cost-sharing protections requirements. Examples include:

- New Mexico's 2008 Coordinated Long-Term Services model contract cites the cost-sharing protections regulations in its definition of a co-payment; specifically, that the co-payment amount must be consistent with 42 §§ CFR 447.53 through 447.56. These regulations express Medicaid cost-sharing exclusions for categorically eligible or medically needy groups and also articulate the requirement that "no provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing."

- A 2005 Washington Medicare/Medicaid Integration Partnership contract includes a provision for inflicting sanctions against a contractor for imposing premiums or other charges on enrollees that are in excess of amounts "permitted under law or under this agreement."

- Virginia's 2008 Acute and Long-Term Care Services contract includes a provision for imposing sanctions against the contractor should the contractor require premiums or charges "in excess of the premiums or charges permitted under Title XIX" of the Social Security Act.

Please note that nearly all examples were created before the promulgation of MIPPA; as such, the contracts do not mention the additional cost-sharing protections described in MIPPA 165.

## MIPPA Requirement 5: The contract must document the identification and sharing of information on Medicaid provider participation

A key element in improving the Dual SNP's potential for better integrating Medicare and Medicaid benefits for dual eligibles is to ensure that MA organizations are aware of which providers in the service area accept Medicaid and, more importantly, that MA organizations contract with an adequate number of Medicaid providers so that dual eligibles can seamlessly access both sets of benefits within a single network. MA organizations, per Chapter 4 of the *Medicare Managed Care Manual,* are required to "maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served;"[5] as such, the Dual SNP contract must account for some level of data sharing between the MA organization and the State, regardless of the services performed by the SNP, by including a process for the State to identify and share information on providers contracted with the State Medicaid agency for inclusion in the SNP provider directory. However, as stated earlier, data sharing alone will not satisfy MIPPA contracting requirements.

Existing contracts between States and Medicaid managed care organizations typically provide detailed requirements for the contractor to regularly update the State with changes to the contractor's provider network. States can use these existing relationships as examples for crafting data-sharing contract provisions.

[5] As mentioned previously, Dual SNPs must meet all applicable Medicare Advantage program requirements.

## MIPPA Requirement 6: The contract must document the verification of enrollee's eligibility for both Medicare and Medicaid

Existing contracts between States and Medicaid managed care organizations – including contracts mandating that the Medicaid managed care organization also offer a Medicare Advantage SNP – generally limit the scope of eligibility verification to eligibility for Medicaid. However, these contracts do provide insight on how a future contract could be structured to include a detailed provision – required by CMS – for the State Medicaid agency to provide the MA organization with access to real-time information verifying the eligibility of enrolled dual eligible members. The following paragraphs express several possible options for how this requirement may be satisfied.

### Option 1: Include a data-sharing provision in the contract for the State and SNP to exchange real-time Medicaid eligibility information

For a State who wishes to pursue a contract with an MA organization who is not already operating in the State as a Medicaid managed care organization, or for an exclusive fee-for-service Medicaid State, the State may wish to negotiate with the MA organization to include a data-sharing provision in the contract requiring the SNP to regularly provide the State with individual-level enrollment information. Under this option, the State responsible for making a real-time determination of Medicaid eligibility based on the enrollment information provided by the SNP and informing the SNP of this determination. That is, the State is required to provide an automatic Medicaid eligibility determination to the MA organization as it receives an enrollee eligibility inquiry from the MA organization. In concurrence with submitting enrollment information to the State, the SNP will be responsible for verifying Medicare eligibility by completing CMS' Batch Eligibility Query (BEQ) process or performing a MARx online query.

In addition to initially verifying Medicaid eligibility, the SNP is responsible for regularly verifying that the enrollee remains eligible for continued enrollment in the plan. Per Section 20.11 of Chapter 2 of the *Medicare Managed Care Manual*, the SNP must "verify continuing eligibility (e.g., full or partial dual status, as applicable) at least as often as the state Medicaid agency conducts re-determinations of Medicaid eligibility." Therefore, under this option, the contract between the State and the sponsoring MA organization should include a provision for the SNP to send eligibility verification data to the State at least as often as the State conducts re-determinations of its Medicaid-eligible population.

### Option 2: Include a provision in the contract describing the process by which the SNP verifies Medicaid eligibility through a third party vendor

For States who do not wish to respond to Medicaid eligibility inquiries directly, or lack the information technology resources to successfully transmit eligibility data to the SNP, the State may direct the SNP to utilize a third party vendor with whom the State has a contractual relationship for verifying Medicaid eligibility in real time on the State's behalf. Under this option, the SNP is still responsible for verifying Medicare eligibility through the BEQ process or MARx query, as well for as re-determining the enrollee's Medicaid eligibility (determined through enrollee documentation, submission of enrollee data to the State for verification, or other approved method) at least as frequently as the State performs this re-determination.

### Option 3: Include a provision in the contract describing the process by which the SNP verifies Medicaid eligibility based on documentation provided by the enrollee

Rather than rely exclusively on the State (or a third party vendor) to verify Medicaid eligibility from submissions of individual-level enrollment data, the SNP can make a determination of Medicaid eligibility based on documentation submitted by potential enrollees. Per Section 20.11 of Chapter 2 of the *Medicare Managed Care Manual*, the SNP may confirm Medicaid eligibility through receipt of a copy of the enrollee's current Medicaid card or a letter from the State Medicaid agency confirming the enrollee's eligibility for Medicaid. Under this option, the SNP is still responsible for verifying Medicare eligibility through the process described in Option 1 as well as re-determining the enrollee's Medicaid eligibility (determined through enrollee documentation, submission of enrollee data to the State for verification, or other approved method) at least as frequently as the State performs this re-determination.

### Option 4: Expand upon existing Medicaid managed care contractual eligibility requirements to include a provision for verifying Medicare eligibility

For an MA organization that already has a contract with a State to operate as a Medicaid managed care organization, no additional data-sharing protocol is required to verify Medicaid eligibility so long as the MA organization has real-time access to this information. When the SNP receives an enrollment application, it will determine if the applicant is already receiving Medicaid benefits under the SNP's Medicaid managed care contract; if so, re-verifying Medicaid eligibility is not required. If the applicant is not known to the SNP, the SNP will follow its existing protocols for verifying the applicant's Medicaid eligibility with the State. The SNP will follow standard CMS protocols for Medicare eligibility verification and enrollment into the Medicare Advantage plan, as well as periodic re-determinations of Medicaid eligibility.

New York's 2006 Medicaid Advantage model contract provides examples of eligibility verification for "known" applicants (i.e., applicants who are already enrolled in the contractor's Medicaid managed care product) as well as "unknown" applicants. The New York Medicaid Advantage program provides integrated Medicaid and Medicare services to dual eligibles. All contractors participating in the program must be participants in New York's Medicaid managed care program and must also have contracts from CMS to operate as Medicare Advantage Organizations. The New York contract articulates a process where the State (via the Local Department of Social Services (LDSS)) is responsible for processing enrollment applications to "transfer" applicants who are already members of the contractor's Medicaid managed care product into the contractor's Medicare Advantage product (i.e., the Dual SNP) without re-verifying Medicaid eligibility. For "unknown" applicants who are not already enrolled in the contractor's Medicaid managed care product, the contract articulates the following process for verifying Medicaid and Medicare eligibility:

- Before submitting an enrollment application for an unknown applicant to the LDSS, the contractor is responsible for verifying Medicare A and B eligibility – such as by obtaining a Medicare card from the applicant or querying CMS systems – and providing documentation demonstrating Medicare eligibility to the LDSS.

- The LDSS determines the eligibility status of the enrollee, i.e., determines if the applicant is eligible for Medicaid and that documentation has been provided indicating the applicant is also eligible for Medicare, and sends the applicant notice of acceptance or denial of enrollment into the Medicaid Advantage program. The contractor is responsible for transmitting the applicant's information to CMS for enrollment in the contractor's Medicare Advantage plan (Dual SNP). Should CMS reject the Medicare Advantage enrollment request, the contractor is responsible for informing the LDSS, who will then retroactively disenroll the enrollee from the Medicaid Advantage product.

A 2009 contract between Minnesota and a concurrent Medicaid managed care organization/Dual SNP for providing integrated Medicaid and Medicare benefits under the Minnesota Senior Health Options (MSHO) program provides another example of effective utilization of existing data-sharing protocols to verify Medicaid and Medicare eligibility. MSHO is a voluntary program providing integrated Medicare and Medicaid acute and long-term care services to qualifying senior citizens who would otherwise be enrolled in a mandatory Medicaid-only managed care program; as such, Medicaid eligibility has generally already been established at the time of enrollment. The contract articulates a process for verifying Medicare eligibility, where the MSHO contractor is responsible for querying CMS' MARx or Medicare Beneficiary Database (MBD) to verify the enrollee's Medicare status, and submitting a copy of the CMS eligibility screen print along with the enrollment application to the State for ultimate verification of eligibility for the MSHO program.

## MIPPA Requirement 7: The contract must document the service area covered by the SNP

States can meet this straightforward requirement by including the service area in the contract, i.e., the counties in the State that the SNP will cover. At minimum, all counties included in the CMS-approved contract service area for the Dual SNP must be included in the contract between the State and the MA organization. Please note that the Dual SNP's Medicare contract service area cannot be modified after the MA organization submits its bid to CMS on the first Monday of June.

## MIPPA Requirement 8: The contract must document the contract period for the SNP

Any contract between a State Medicaid Agency and an MA organization must clearly document the effective dates of the agreement. In order for CMS to approve the contract, the contract must span the entire Medicare Advantage contract implementation year (e.g., January 1, 2010 through December 31, 2010). In addition, contracts may incorporate an evergreen provision, allowing for automatic renewal (with or without mention of any rate changes). States who already have contracts in place with Dual SNPs may extend their existing contracts so that they cover the entire Medicare Advantage contract year, provided that the contracts meet all other MIPPA requirements.

# Appendix A: Contract Language Examples

This Appendix presents selected excerpts from several existing and historical contracts between States and Medicaid managed care organizations.[6] These excerpts are intended to provide States with useful language examples to aid States in their development of MIPPA-compliant contracts with MA organizations.

| MIPPA Req. # | MIPPA Requirement or Option Description | Contract Language Example |
|---|---|---|
| 2 | The contract must document the category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP | *From the 2008 Virginia Acute and Long-term Care Services (VALTC) model contract:*<br><br>"Existing and newly enrolled full benefit dual eligibles: individuals enrolled in Medicare and eligible for Medicaid coverage. These participants are included in the Virginia Administrative Code as "Qualified Medicare Beneficiaries (QMB) Plus." This program will not include individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements. This program also will not include "non" full benefit dual eligibles such as:<br>• Qualified Medicare Beneficiaries (QMBs),<br>• Special Low Income Medicare Beneficiaries (SLMBs),<br>• Qualified Disabled Working Individuals (QDWIs), or<br>• Qualified Individuals (QI)"<br><br>Note: This contract was obtained through the Virginia Department of Medical Assistance Services, who has approved its use in this paper |
| 4 | Option 1: Include specific language on cost-sharing protections in the contract - *Adherence to enrollment fees, premiums and other cost-sharing requirements* | *From the 2003 MassHealth Senior Care Options model contract*:*<br><br>"Because the Senior Care Options Program is available to both dually eligible and Medicaid-only seniors, Medicare beneficiary premiums and cost-sharing requirements are waived. The Contractor must submit a modified Adjusted Community Rate." The contract also states that the Contractor must "not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract" |

[6] All contracts noted with asterisks (*) were obtained via the Center for Health Care Strategies' website (http://www.chcs.org/publications3960/publications_show.htm?doc_id=606732).

| MIPPA Req. # | MIPPA Requirement or Option Description | Contract Language Example |
|---|---|---|
| 4 | Option 1: Include specific language on cost-sharing protections in the contract - *Adherence to enrollment fees, premiums and other cost-sharing requirements* | *From a 2009 Minnesota Senior Health Options contract:*<br><br>"The MCO is responsible for payment of Medicaid covered Medicare cost sharing where applicable." In addition, "the MCO will not bill or hold the Enrollee responsible in any way for any charges or deductibles, for Medically Necessary Covered Services or services provided as alternatives to Covered Services as part of the MCO's Care Management Plan. The MCO shall ensure that its subcontractors also do not bill or hold the Enrollee responsible in any way for any charges or deductibles for such services. The MCO shall further ensure that an Enrollee will be protected against liability for payment when: (A) The MCO does not receive payment from the STATE for the Covered Services; (B) A health care Provider under contract or other arrangement with the MCO fails to receive payment for Covered Services from the MCO; (C) Payments for Covered Services furnished under a contract or other arrangement with the MCO are in excess of the amount that an Enrollee would owe if the MCO had directly provided the services, and D) A non-Participating Provider does not accept the MCO's payment as payment in full."<br><br>Note: This contract was obtained through the Minnesota Department of Human Services, who has approved its use in this paper |
| 4 | Option 1: Include specific language on cost-sharing protections in the contract - *Adherence to enrollee protections from liability requirements* | *From the New Mexico 2008 Coordinated Long-Term Services (CLTS) model contract*:*<br><br>"Members shall be held harmless against any liability for debts of the CONTRACTOR that were incurred within the Agreement in providing the CLTS benefit package to the Member, excluding any Member's liability for copayments or Member's liability for overpayment resulting from benefits paid pending the result of a Fair Hearing." |

| MIPPA Req. # | MIPPA Requirement or Option Description | Contract Language Example |
|---|---|---|
| 4 | Option 1: Include specific language on cost-sharing protections in the contract - *Adherence to enrollee protections from liability requirements* | *From the 2008 Virginia Acute and Long-term Care Services (VALTC) model contract:*<br><br>"Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), the MCO and all of its subcontractors shall not hold a participant liable for:<br>i. Debts of the MCO in the event of the MCO's insolvency;<br>ii. Payment for services provided by the MCO if the MCO has not received payment from the Department for the services or if the provider, under contract or other arrangement with the MCO, fails to receive payment from the Department or the MCO; or<br>iii. Payments to providers that furnish covered services under a contract or other arrangement with the MCO that are in excess of the amount that normally would be paid by the participant if the service had been received directly from the MCO.<br><br>The MCO, including its network providers and subcontractors, shall not bill an enrollee for any services provided under this contract. The MCO shall assure that all in network provider contracts include requirements whereby the enrollee shall be held harmless for charges for any Medicaid covered service." |
| 4 | Option 1: Include specific language on cost-sharing protections in the contract - *Adherence to enrollee protections from liability requirements* | *From the 2007 Wisconsin Partnership Program model contract*:*<br><br>All subcontractors must agree "To ensure that all contractual or other written arrangements with providers prohibit the MCO providers from holding any beneficiary member liable for payment of any fees that are the legal obligation of the MCO as per:<br>• 42 CFR 422.502(q)(l)(i) Contract Provisions between the MEDICARE ADVANTAGE and CMS<br>• 1903(m)(L)(A)(ii) of the SSA – Contract Provisions, Beneficiary Financial Protection" |
| 4 | Option 1: Include specific language on cost-sharing protections in the contract – *Adherence to sanctions requirements* | *From the 2006 New York Medicaid Advantage model contract*:*<br><br>"Contractor is subject to imposition of sanctions as authorized by 42 CFR 422, Subpart O. In addition, for the Medicaid Advantage Program, the Contractor is subject to the imposition of sanctions as authorized by State and Federal law and regulation, including the SDOH's right to impose sanctions for unacceptable practices as set forth in 18 NYCRR Part 515 and civil and monetary penalties as set forth in 18 NYCRR Part 516 and 43 CFR § 438.700, and such other sanctions and penalties as are authorized by local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program or to the delivery of the contracted for services.<br><br>Unacceptable practices for which the Contractor may be sanctioned include, but are not limited to . . . Imposing premiums or charges on Enrollees that are in excess of the premiums or charges permitted under the Medicaid Advantage Program." |

| MIPPA Req. # | MIPPA Requirement or Option Description | Contract Language Example |
|---|---|---|
| 4 | Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements | *From the New Mexico 2008 Coordinated Long-Term Services (CLTS) model contract*:*<br><br>"'Co-payment' means a monetary amount specified by the State that the Member pays directly to the provider at the time Covered Services are rendered consistent with 42 C.F.R. §§447.53 through 447.56." |
| 4 | Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements | *From a 2005 Washington Medicare/Medicaid Integration Partnership contract*:*<br><br>"DSHS, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions, in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210, against the Contractor for . . . Imposing premiums or charges on enrollees that are in excess of the premiums or charges permitted under law or under this agreement." |
| 4 | Option 2: Cite the sources of the cost-sharing protections requirements in the contract rather than include the specific requirements | *From the 2008 Virginia Acute and Long-term Care Services (VALTC) model contract:*<br><br>Sanctions may be imposed "if the managed care organization . . . imposes premiums or charges enrollees in excess of the premiums or charges permitted under Title XIX of the Act." |
| 6 | Option 4: Expand upon existing Medicaid managed care contractual eligibility requirements to include a provision for verifying Medicare eligibility | *From a 2009 Minnesota Senior Health Options contract:*<br><br>"Prior to submitting an enrollment form to the STATE, or entering enrollment information on MMIS, the MCO must verify Medicare status of the Potential Enrollee via the Medicare Advantage and Prescription Drug user Interface (MARx)/MBD or other system as directed by the STATE and CMS. A copy of the CMS eligibility screen print must be included with any enrollment form submitted to the STATE. The MCO must ensure that appropriate MCO staff have access to the MN-ITS and appropriate Medicare eligibility and managed care systems as directed by the State and CMS including MARx." |

# Appendix B: Definitions of Key Concepts

## I. Dual Eligible Categories

This section describes the various categories of individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit[7]. Collectively, they are known as dual eligibles.

**Medicaid Only:** Eligible for Medicaid benefits, categorically, or through optional coverage groups such as medically needy or special income levels for institutionalized or home and community-based waivers, but do not meet the income or resource criteria for QMB or SLMB. Federal financial participation (FFP) is Federal medical assistance percentage (FMAP).

**Qualified Medicare Beneficiary (QMB):** Entitled to Medicare Part A, income of 100% FPL or less, and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple). FFP is FMAP.

**QMBs with Full Medicaid Benefits (QMB-Plus):** Entitled to Medicare Part A, income of 100% FPL or less, and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple), and are eligible for full Medicaid benefits. FFP is FMAP.

**Specified Low-income Medicare Beneficiary (SLMB):** Entitled to Medicare Part A, income above 100% FPL but less than 120% FPL, and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple). FFP is FMAP.

**SLMBs with Full Medicaid Benefits (SLMB-Plus):** Entitled to Medicare Part A, income above 100% FPL but less than 120% FPL, and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple), and are eligible for full Medicaid benefits. FFP is FMAP.

**Qualifying Individual (QI-1):** Entitled to Medicare Part A, income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple) and not otherwise eligible for Medicaid benefits. FFP is 100% Federal.

**Qualifying Individual (QI-2):** Entitled to Medicare Part A, income at least 135% FPL but less than 175% FPL, and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple) and not otherwise eligible for Medicaid benefits. FFP is 100% Federal.

**Qualified Disabled and Working Individual (QDWI):** Lost Medicare Part A benefits due to return to work, but is eligible to enroll in and purchase Medicare Part A. Must have income of 200% FPL or less and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple) and not otherwise eligible for Medicaid benefits. FFP is FMAP.

[7] For additional information, please refer to: http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp

## II. Medicaid Benefits

Unless waived under Section 1115 of the Social Security Act, State Medicaid plans are required to cover a core set of services for those who are categorically eligible for Medicaid benefits. These mandatory benefits include:

- Inpatient hospital (excluding inpatient services in institutions for mental disease)
- Outpatient hospital including Federally Qualified Health Centers (FQHCs) and if permitted under State law, rural health clinic and other ambulatory services provided by a rural health clinic which are otherwise included under States' plans
- Other laboratory and x-ray
- Certified pediatric and family nurse practitioners (when licensed to practice under State law)
- Nursing facility services for beneficiaries age 21 and older
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- Family planning services and supplies
- Physicians' services
- Medical and surgical services of a dentist
- Home health services for beneficiaries who are entitled to nursing facility services under the State's Medicaid plan
  - Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area
  - Home health aides
  - Medical supplies and appliances for use in the home
- Nurse midwife services
- Pregnancy related services and service for other conditions that might complicate pregnancy
- 60 days postpartum pregnancy related services

Additional services may be provided in States who opt to include "medically needy" individuals under their Medicaid plans, or who use a waiver to expand covered benefits. For some individuals dually eligible for Medicare and Medicaid, known as Qualified Medicare Beneficiaries (QMBs), Medicaid pays the dual eligible's Medicare premiums, deductibles and coinsurance. Medicaid covers other Medicare costs for individuals in other dual eligible categories.

## III. Medicaid Subset

The meaning of "Medicaid subset" has created confusion among MA organizations as well as States, many of whom believe that the term refers to a limited sub-population of dual eligibles. The *2010 Call Letter* clarifies that a Medicaid subset "a) serves dual eligible beneficiaries, b) has an executed State Medicaid Agency contract, and c) enrolls the Medicaid population identified in the executed State Medicaid Agency contract as the target population."