MEDICAID CONTRACTS WITH MEDICARE SPECIAL NEEDS PLANS REFLECT DIVERSE STATE APPROACHES TO DUALLY ELIGIBLE BENEFICIARIES

This issue brief--written by Paul Saucier, Jessica Kasten and Brian Burwell--is the first of three commissioned by the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation on the federal Medicare Special Needs Plans (SNPs) authority. This brief focuses on an in-depth look at five SNP-State contracts. The remaining briefs address: SNP provisions impacting Medicaid programs, and the nature and extent of SNP-State contracting in 2008.

Introduction

Persons who are dually eligible for Medicare and Medicaid account for a disproportionate share of expenditures under both programs. In Medicare, dual eligibles account for 16% of beneficiaries and 25% of total expenditures, incurring nearly twice the expenditures of Medicare-only beneficiaries.[1] Under Medicaid, dual eligibles account for 18% of beneficiaries and 46% of total Medicaid spending.[2]

Because dual eligibles receive health care and long-term services benefits under two entirely different public insurance programs and through two largely different care systems, it has long been recognized that services for dual eligibles are fragmented and inefficient. Consequently, increased attention is being placed on the development of care management models that can potentially manage the full spectrum of Medicare and Medicaid benefits for dual eligibiles in a manner that both improves consumer outcomes and reduces public costs.

[1] Medicare Payment Advisory Commission, "Dual-eligible Beneficiaries." In A Data Book: Healthcare Spending and the Medicare Program, June 2009.

[2] Kaiser Commission on Medicaid and the Uninsured. Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries, February 2009.

The authorization of Medicare Special Needs Plans (SNPs) under the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 was a significant development that recognized the importance of dual eligibles to both programs.[3] Medicare SNPs are targeted Medicare Advantage (MA) plans that are allowed to limit enrollment to specific subsets of Medicare beneficiaries, including dual eligibles. Since the enactment of the MMA, the number of Dual Eligible SNPs has grown rapidly. By September 2009, there were 407 Dual Eligible SNPs operating nationwide, with total enrollment of 951,590.[4]

Initially, SNPs were encouraged by the Centers for Medicare and Medicaid Services (CMS) to coordinate Medicare-covered services with whatever Medicaid benefits their members were also eligible to receive, but no formal coordination requirements existed. This changed under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, in which Congress required dual eligible SNPs to have contracts with their state Medicaid programs that formally address coordination of Medicare and Medicaid benefits for their members.

This paper is the third in a series sponsored by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation on SNPs and their relationship to Medicaid. In the second paper of the series, we identified all states which had some kind of contractual relationship with SNPs prior to MIPPA, and classified those relationships into broad categories.[5] The purpose of this third paper is to examine in greater detail a select group of state contracts with SNPs to determine how states use contracts to achieve Medicaid policy goals and advance care integration for dually eligible beneficiaries. As the link between state Medicaid programs and Medicare SNPs evolves further under the requirements of MIPPA, states may benefit from an analysis of existing contracting practices.

Approach and Scope

The previous paper in this series identified a wide range of agreements reflecting the unique purchasing strategies of state Medicaid programs. From the earlier analysis, five program contracts were selected for more in-depth analysis to identify how particular aspects of dual eligibility and managed long-term services are addressed across a diverse set of state programs. The five programs from which contracts

[3] Saucier, P., Kasten, J., and Burwell, B. Federal Authority for Medicare Special Needs Plans and Their Relationship to State Medicaid Programs. ASPE Series on Special Needs Plans and State Medicaid Programs: Issue Brief No. 1, June 2009. [http://aspe.hhs.gov/daltcp/reports/2009/leghist.htm]

[4] CMS. Special Needs Plan Comprehensive Report--September 2009. In total, there are about 8.8 million dual eligibles nationwide, so about 12% of all duals were enrolled in SNPs in September 2009.

[5] Saucier, P., Kasten, J., and Burwell, B. State Purchasing Strategies Drive State Contracts with Medicare Special Needs Plans. ASPE Series on Special Needs Plans and State Medicaid Programs: Issue Brief No. 2, June 2009 (Draft). [http://aspe.hhs.gov/daltcp/reports/2009/stpur.htm]

were selected are summarized in Table 1. By design, the programs represent a broad range of state initiatives, from Minnesota's highly integrated Senior Health Options (MSHO) program to a new cost-sharing program in Texas, with three other programs falling in between.

It should be noted that three states included in this analysis have more than one type of SNP-based program operating. Minnesota, New York and Texas all have other types of contracts that relate to other distinct program initiatives in those states. We have chosen to feature one contract from each of those states because it represents a point in a national continuum of SNP-state contracts.

Contract Analysis by Topic

The five contracts were analyzed by major topics of interest:

- Program Purpose
- Enrollment and Marketing
- Medicaid Services Included
- Care Coordination
- Access/Network Adequacy
- Data Reporting
- Quality
- Financial Incentives

For each topic, we offer a summary of the range of content identified in contracts, illustrated with actual contract language. We added underscoring to highlight key phrases and excised passages to keep selections short, but otherwise the contract language is as it appears in actual SNP-state contracts.

Purpose of Contract

The purpose statement contained in each SNP-state contract provides a good indicator of how far the rest of the contract will go in specifying Medicaid services, their integration with Medicare services, care coordination, quality provisions, reporting requirements and a host of other items. As one would expect, states seeking full integration of Medicare and Medicaid services enter into the most comprehensive and specific contracts, and states seeking cost-sharing-only agreements the least.

In the middle are states that have as their primary goal more effective delivery of Medicaid long-term services, and which enter into contracts with SNPs to allow for Medicare integration as a secondary benefit. Table 2 offers examples of the range of purpose statements found in SNP-state contracts.

The Minnesota contract seeks a fully integrated, alternative delivery system for dual eligibles, a goal that manifests in a nearly 200 page contract plus appendices. The relatively modest goal of capitating cost-sharing in Texas requires much less oversight and is governed by a 20 page contract.

Minnesota and New Mexico both mention long-term services in their purpose statements, and each contract goes on to include long-term services in its Medicaid capitation. In contrast, the Texas contract is not designed to address long-term services, and does not mention them.

Minnesota and New Mexico differ in their primary objective. The MSHO program's reason for being is to integrate Medicare and Medicaid services. The Coordinated Long-Term Services (CoLTS) program seeks first and foremost to deliver long-term services more effectively. By requiring its contractors to be SNPs, New Mexico is encouraging contractors to integrate Medicare and Medicaid when possible, as a secondary benefit of the program.

Enrollment and Marketing

Under federal policy, MA enrollment is always voluntary, and dual eligibles may leave or change plans on a month-to-month basis. Medicaid policy, on the other hand, allows mandatory enrollment with appropriate waivers, and permits lock-in periods. This creates a range of Medicare-Medicaid enrollment dynamics, depending on the enrollment policy decisions made by state officials.[6]

Table 3 illustrates the range of policy options available to a state and how they play out. New York's Medicaid Advantage Plus (MAP) contract includes two key enrollment policy decisions. First, the state opted to mirror Medicare enrollment policy. Enrollment is voluntary for both Medicare and Medicaid, with no lock-in period. Secondly, New York made an additional policy decision to underscore that the unique benefit of this program is Medicare-Medicaid integration. The state will only enroll a beneficiary for Medicaid services if the beneficiary has opted to enroll with the SNP for Medicare.

In contrast, the New Mexico CoLTS contract establishes a mandatory Medicaid program with a 12-month lock-in period (with one switch allowed in the first 90 days). In CoLTS, Medicaid enrollment policy takes precedence, and because Medicare enrollment can never be mandatory, integrated care is available to a subset of members who choose to enroll for Medicare as well. In the New York contract, 100% of Medicaid members will be dually enrolled for Medicare as well, but the overall enrollment is likely to be relatively low. In New Mexico, the state achieves high Medicaid enrollment, but limited penetration of dual enrollment into both Medicaid and Medicare.

Finally, the Minnesota contract offers a hybrid that reflects the state's overall Medicaid managed care strategy. In Minnesota, the default option for older persons is the mandatory Senior Care Services program, a Medicaid-only program. MSHO is structured as a fully voluntary option for those who choose

[6] Ibid. See also Grabowski, D. (2009). Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles. *Health Affairs* 28(1):136-146, and Saucier, P., and Burwell, B. (2007). *Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care*. Prepared for CMS.

integrated care, and the state mirrors Medicare enrollment policy in that program. Those who do not choose MSHO are enrolled in the mandatory Senior Care Services program.

Contracts also address a more technical enrollment issue. Two separate processes must take place to achieve dual Medicare and Medicaid enrollment. Beneficiaries must be enrolled into CMS' MA system for Medicare, and into a state's enrollment system for Medicaid. Alignment of enrollment dates is important for creating a seamless beneficiary experience and for paying plans appropriately.

Table 4 shows how Minnesota and New York address coordination of Medicare and Medicaid enrollment. In MA, enrollment is effective on the first day of the month following approval of the beneficiary's enrollment. The Minnesota contract language mirrors the Medicare effective date for MSHO only. For those enrolled in the non-integrated Senior Care Services program, enrollment is effective on the first day of the *second* month following approval. But for purposes of achieving seamless, dual integration for MSHO members, the state opted to adapt its standard Medicaid enrollment policy to align it with Medicare policy.

New York's language is slightly different, containing a two-part test. To be enrolled for Medicaid, a beneficiary must appear on the state enrollment roster *and* must be enrolled for Medicare. The language may or may not result in a unified Medicaid and Medicare enrollment date, since getting on the state enrollment roster generally takes longer than enrollment in Medicare, depending on when during the month the beneficiary has opted to enroll. It does ensure, however, that no one can be enrolled in MAP unless the person has enrolled for Medicare. This reinforces the state's policy (illustrated in Table 3) that it will not enroll Medicaid beneficiaries unless they have also selected the plan's Medicare product.

Marketing is an important aspect of enrollment. Table 5 shows a range of contract approaches.

Minnesota uses the contract to assert state review of all materials, including Medicare materials. The Idaho contract, on the other hand, limits the state role to reviewing Medicaid material, and defers to CMS on review of Medicare material. The Texas contract takes a different approach altogether by creating an incentive for plans to submit material to the state. Plans that submit comparison charts for state approval then have the advantage of having their product summarized on material provided by the state to dual eligibles.

SNP-state contracts give states opportunity to regulate what materials are presented to dually eligible beneficiaries and reduce confusion in their markets. The opportunity for plans is to obtain endorsement and assistance from states in marketing to dually eligible beneficiaries.

Medicaid Services Included

A broad range of Medicaid services are provided through SNPs under capitation. They are generally listed in contract appendices too long to reproduce here. Table 6 provides a summary.

Not surprisingly, the Texas contract capitates cost-sharing only, since that is the purpose of the contract. On the other end of the spectrum, Minnesota includes virtually all Medicaid services in its capitation to SNPs, reflecting its policy goal of a fully integrated product. New Mexico also includes an extensive package of services in its capitation, with the exception of behavioral health services. That exclusion stems from the state's earlier decision to deliver behavioral health services through a statewide behavioral health services organization. Idaho's Benchmark program was designed with the state's relatively healthy dual eligibles in mind, and therefore does not include long-term services.

Regardless of whether services are included in a capitation or continue to be paid on a fee-for-service basis, most of the contracts recognize the overlap in Medicare and Medicaid benefits and define certain Medicaid benefits in relationship to Medicare. Table 7 offers examples.

As long as Medicare and Medicaid funding continue to be accounted for separately (as they must be under current federal authority), the possibility of cost shifting exists, even in highly integrated programs like Minnesota's. The examples in Table 7 all seek to get expenditures allocated to the appropriate ledger. Even in the context of fully capitated payments, how an encounter is recorded will impact cost reporting, potentially affecting future rate setting.

Of particular concern in several contracts is coordination of drug benefits, as the examples in Table 8 illustrate. This area has many coordination pitfalls, including: (1) most state Medicaid programs cover prescription drugs not covered by Medicare Part D; (2) Part D plans and state Medicaid programs have different drug formularies; and (3) Part D plans and state Medicaid programs have different pharmacy dispensing networks, and different dispensing fee arrangements with their networks.

States also seek added value for dually eligible beneficiaries by creating contractual obligations for the plans to provide benefits that would not otherwise be provided by Medicaid. Minnesota specifically obtained elimination of Medicaid co-payments. New Mexico created a generic expectation, to be made specific by the contractor.

Care Coordination

All of the contracts included in this analysis include care coordination expectations. The way care coordination is described varies with the program model, as the examples in Table 10 illustrate.

In MSHO, where virtually all Medicare and Medicaid services are the responsibility of the SNP, care coordination is defined very broadly to include all Medicare and Medicaid services. In the MSHO model, these are all within the control of the contractor, which receives comprehensive capitated payments for Medicare and Medicaid, including Medicaid long-term services.

In contrast, Idaho's Benchmark program includes few Medicaid services in its capitation to the SNP. Long-term services remain fee-for-service, and there is no payment to the plan for waiver services or other Medicaid-funded care coordination. The contract instead provides funding for primary care case management (PCCM), and makes the primary care providers responsible for coordination of Medicare and Medicaid benefits. This approach reflects the state's expectation that few, if any, Benchmark Plan members use long-term services.

Finally, the language contained in the Texas Cost-Sharing contract anticipates that coordination will be needed between the SNP's Medicare services and separately managed long-term services. (This contract capitates cost-sharing only, so long-term services, when needed, will be accessed on a fee-for-service basis or through Star+Plus plans, depending on the region.) Texas does not include any payment for care coordination in this contract, but creates a clear expectation that the SNP will provide it as needed to coordinate with Medicaid.

Consumer participation in care planning is an important concept that has been emphasized increasingly in Medicaid home and community-based waiver and other long-term services programs. This emphasis is evident to varying degrees in SNP-state contracts that include long-term services, as shown in Table 11.

Arguably, the New Mexico language goes the farthest to assert consumer control, and this may be related to the program design. The New Mexico program was designed as a mandatory Medicaid long-term services program, with Medicare integration as a secondary goal. The program includes younger persons with disabilities, who, in most states, advocate more forcefully for consumer control than older persons.

Access/Network Adequacy

SNP-state contracts have requirements related to the adequacy of SNP provider networks that go beyond federal MA requirements. Table 12 shows how this is approached in contracts with capitated Medicaid services (Minnesota and New York), and how Texas approaches the issue in its cost-sharing contract.

By referencing "all Covered Services" and all of the benefits "in Appendix K-1 and K-2," Minnesota and New York create broad adequacy expectations that apply to all of the Medicare and Medicaid services provided through those SNPs.

In the Texas Cost-Sharing contract, the goal is better coordination between the SNP's Medicare services and Medicaid services that will be provided out-of-network. Rather than focusing on the network, the state has created a standard around notification. The SNP must have and notify its members and providers about Medicaid providers in the region.

In addition to general adequacy standards, SNP-State contracts have provisions specific to long-term services. Table 13 shows a range of approaches to ensuring access to long-term services.

In Minnesota, very specific types of long-term services are defined and workforce qualifications are specified. (In addition to the personal care assistant [PCA] example shown here, the contract defines, for example, Home Health Aide, Specialized Medical Supplies and Equipment, Adult Companion Services, Adult Day Care, Respite Care and Homemaker services.)

New Mexico requires SNPs to train their network providers regarding the CoLTS program. Texas, which does not include long-term services in its cost-sharing contracts with SNPs, requires the SNPs to provide training to their Medicare network providers regarding Medicaid long-term services, making it more likely that the Medicare providers will know how and where to make long-term service referrals.

Many traditional Medicaid long-term services are informal relative to Medicare services, and are not necessarily familiar to MA plans. Some long-term services advocates fear that the process of Medicaid-Medicare service integration will formalize and "medicalize" long-term services. Having specific contract provisions that describe long-term services and the qualifications of those who deliver them, and requiring training of the SNP's network providers, are ways of addressing these concerns.

Data Reporting

Most SNP-state contracts require submission of encounter data to the state, although the scope of encounters varies. Minnesota and New York both require all Medicare and Medicaid encounters to be submitted, while New Mexico requires only Medicaid encounters. This probably reflects the fact that New Mexico CoLTS is primarily a Medicaid long-term services programs, with only a small minority of members also enrolled in the SNPs' Medicare products. The Texas Cost-Sharing contract calls for submission of Medicare encounters to the state, presumably so the state can assess the appropriateness of its cost-sharing capitation amount from year to year.

Some states require SNPs to submit copies of information provided to CMS as part of the MA bid and cost reporting processes. Table 14 provides examples. In Minnesota, Medicare bid information is provided directly to the state's actuaries.

Some states also require functional data to be submitted, as shown in Table 15. Although none of these states presently use this functional data to adjust payments for risk, they may be using the information to compare their SNP-based programs with other programs, including fee-for-service. They may also be using the data to develop and test risk adjustment methods for future application.

States also require SNPs to submit a range of performance data. These are addressed in the next section.

Quality Provisions

State contracts tend to build on the Medicare quality requirements that SNPs are already required to follow. Typically, the state contract calls for SNPs to submit copies of whatever quality data they are providing to CMS, which often includes Medicare Health Plan Employer Data and Information Set (HEDIS) data, Consumer Assessment of Health Providers and Systems (CAHPS) survey data and the Health Outcome Survey (HOS). Table 16 offers examples.

States appear to be balancing a desire to integrate and streamline quality reporting with a need to collect data that is specifically relevant to dual eligibles. Minnesota, for instance, allows SNPs to use Medicare Performance Improvement Projects (PIPs) to meet Medicaid requirements, but only if the PIPs are approved by the state as being applicable to its population. New Mexico specifies that the state's Medicaid version of CAHPS must be used, and duals must be included in the survey.

States also supplement Medicare quality requirements with provisions addressing care coordination and long-term services. Table 17 offers examples.

Table 18 illustrates how the primary orientation of a program influences contract language on grievances and appeals. The Minnesota contract, with its emphasis on dual eligibility, recognizes both Medicare and Medicaid processes in its SNP contract, making clear that beneficiaries have access to either or both. New Mexico specifies a Medicaid grievance system without mention of Medicare, again reflecting that the CoLTS program is primarily a mandatory Medicaid managed care program with a minority of members dually enrolled for Medicare.

Financial Incentives

At least two of the contracts contain provisions for special financial incentives. The Minnesota contract specifies two areas, dental access and geriatric evaluation, where plans are required to participate by passing on special incentive payments to providers. The New Mexico contract allows the state to provide incentives for exceptional performance, but does not target particular areas.

Conclusion

SNPs were initially authorized by Congress as specialty MA plans with a focus on improving care for vulnerable subsets of Medicare beneficiaries, including persons dually eligible for Medicare and Medicaid. In the early years of the program, Dual Eligible SNPs proliferated, yet only a small minority had formal contracts with state Medicaid programs. In amending the program to require SNP-state contracts, Congress expressed clearly an expectation that Dual Eligible SNPs actively coordinate Medicare and Medicaid services. Although the requirement currently applies only to new SNPs and expanding SNPs, Congress seems poised to raise the bar for all SNPs. At least one health reform bill (Senate Bill 1796) would require all Dual Eligible SNPs to hold both Medicare *and* Medicaid contracts for their members by January 1, 2013.

Congress and CMS continue to refine the policy objectives of the SNP program, largely from the perspective of the nationally uniform Medicare program. (SNPs are, first and foremost, MA plans.) The contracts in this analysis, however, demonstrate that states engage with SNPs to achieve a broad range of Medicaid policy goals. As Congress continues to work on improving the SNP program, its challenge is to set standards while allowing sufficient flexibility to make Dual Eligible SNPs effective partners in meeting a broad range of state Medicaid program goals.

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Appendix A: Contracts Cited in This Report

Agreement Between the New Mexico Human Services Department, the New Mexico Aging and Long-Term Services Department, and Coordinated Long-Term Services Program Contractors. 2008.

Agreement Between Texas Health and Human Services Commission and Medicare Advantage Dual Eligible Special Needs Plan [for cost-sharing obligations]. 2009.

Idaho PAHP Provider Services Contract for Medicare/Medicaid Coordinated Care. 2008.

Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Services. 2008**.**

New York Medicaid Advantage Plus (MAP) Model Contract. 2007.

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TABLE 1. Features of Selected State Medicaid Programs Contracting with Medicare Dual Special Plans					
	Idaho Coordinated Benchmark Benefit Plan	**Minnesota Senior Health Options (MSHO)**	**New Mexico Coordinated Long-Term Services (CoLTS)**	**New York Medicaid Advantage Plus (MAP)**	**Texas Cost-Sharing**
Inception Date	2007	1997	2008	2008	2008
Duals Age 65+?	Yes	Yes	Yes	Yes	Yes
Dual <Age 65?	Yes	No	Yes	Yes	Yes
Medicaid Enrollment	Voluntary	Voluntary	Mandatory	Voluntary	Voluntary
Long-Term Services in Medicaid Capitation?	No	Yes	Yes	Yes	No
Approach to Medicare	Limited Medicaid wrap-around for dual eligibles who have chosen the SNP for Medicare.	Medicaid and Medicare are integrated by design. All members are dually enrolled for both.	Primarily a Medicaid managed long-term services program. CoLTS contractors maintain SNP status for dually eligible members who may choose to enroll for Medicare as well.	Substantial Medicaid wrap-around for dual eligible members who have chosen the SNP for Medicare.	Capitated cost-sharing-only for SNPs that choose to contract with the state. Medicaid services remain fee-for-services.
Area Covered	24 counties (out of 44)	83 counties (out of 87)	Statewide	5 Upstate counties and New York City	Statewide
Number Enrolled for Medicaid	1,035	37,000	38,000 (est.)	421	39,000 receive cost-sharing benefits*
Federal Authorities	§1937(b) Benchmark, SNP authority for Medicare	§1915(a) authority and §1915(c) waiver for Medicaid, SNP authority for Medicare	§1915(b) and (c) waivers for Medicaid, SNP authority for Medicare	§1915(a) authority for Medicaid, SNP authority for Medicare	None required for Medicaid, SNP authority for Medicare

* They receive cost-sharing benefits from Medicaid via a capitated payment contract, but are not enrolled for Medicaid services.

TABLE 2. Purpose Statements Foreshadow How Comprehensive a Contract Will Be		
MSHO: Integrated Care	**CoLTS: Managed Long-Term Services**	**Texas Cost-Sharing: Capitated Cost-Sharing Only**
This contract implements … MSHO, that creates an alternative delivery system for acute and long-term care services integrating Medicare and Medicaid funding for persons age 65 and over who are dually eligible for Medicare and Medicaid as well as those who are eligible for Medicaid only; … (Article 1)	Due to increased budgetary constraints, a desire to increase efficiency and reduce fragmentation of long-term services, the state shall require that most Medicaid recipients of long-term care services, specifically full dual eligibles …, nursing facility residents, personal care option consumers, and individuals currently receiving disabled & elderly home and community-based waiver services enroll in the state's CoLTS program. (Section 1.3)	Pursuant to the Texas State Plan, the state is financially responsible for the cost-sharing obligations attributable to dual eligible members enrolled in the MA dual SNP's MA product. The state wishes to initiate a program by which the state will pay the MA dual SNP a monthly capitated payment in exchange for the MA dual SNP's payment of such cost-sharing obligations to health care service providers. (Article 1)

TABLE 3. States Have Developed a Range of Contract Provisions in Response to Medicare-Medicaid Enrollment Dynamics		
MSHO	**CoLTS**	**New York MAP**
In its marketing for MSHO, the managed care organization (MCO) must establish and maintain a system for confirming that enrolled Recipients have in fact enrolled in the MCO and understand the rules applicable under the plan. It must have recipients sign a form indicating that they understand that upon voluntary disenrollment from MSHO, they will remain enrolled in the MCO's MSC/MSC+ product, unless they request the state to return them to the MSC/MSC+ product in which they were enrolled immediately prior to enrollment in MSHO. (Section 3.2)	A current contractor member has the opportunity to change MCOs without cause during the first 90 calendar days of a 12-month period … A member is limited to one 90-day switch period per MCO. After exercising the switching rights, and returning to a previously selected MCO, the member shall remain with the MCO until his/her 12-month lock-in period expires before being permitted to switch MCOs. (Section 3.3)	An eligible person's decision to enroll in the contractor's MAP product shall be voluntary. However, as a condition of eligibility for MAP, individuals may only enroll in the contractor's MAP product if they also enroll in the contractor's MA product as defined in this agreement. (Section 6.3)

TABLE 4. Contracts Include Provisions to Align Medicaid and Medicare Enrollment Processes	
MSHO	**New York MAP**
For MSHO duals only, when enrollment has been approved on or before the last day of the month, medical coverage shall commence at midnight, Minnesota time, on the first day of the month following the month in which enrollment was approved. (Section 3.1)	An enrollee's effective date of enrollment shall be the first day of the month in which the enrollee's name appears on the Prepaid Capitation Plan Roster and is enrolled in the contractor's MA product for that month. (Section 6.5)

TABLE 5. CMS is Responsible for Medicare Marketing Under Federal Law, but Some States Have Used Contracts to Create a State Role as Well		
MSHO	**Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan**	**Texas Cost-Sharing**
All client education and marketing materials for MSHO … must be prior approved by the state and CMS. The MCO must submit all materials for review, in a final format to the state prior to receiving an approval from the state, including Medicare materials. The state and CMS shall do a review of all Medicare related materials. Upon receiving state approval of MSHO material, the MCO is responsible for submitting material subject to CMS review, directly to CMS for review.	Contractor shall not distribute any marketing or informational materials intended for enrollees without first obtaining approval from the Department for Medicaid materials and CMS for Medicare materials. (Section XIV.)	The MA dual SNP may work with other MA dual SNPs to develop one or more comparison charts summarizing the products and services offered under the various MA agreements for each service area in the state … The state will review the comparison charts, and help facilitate the distribution of the comparison charts to dual eligibles. (Section 4.03)

TABLE 6. Summary of Capitated Medicaid Services Included in SNP Contracts	
Contract	**Summary of Capitated Medicaid Benefits and Services Provided Through SNP**
Texas Cost-Sharing	Medicare cost-sharing obligations.
Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan	Medicare cost-sharing obligations. Prescription drugs not covered by Medicare. Certain other primary services, including PCCM.
New York MAP	Medicare cost-sharing obligations. Certain other primary services. Certain therapies. Most long-term services.* Behavioral health services.
New Mexico CoLTS	Medicare cost-sharing obligations. Prescription drugs not covered by Medicare. Primary services. Acute services. Long-term services, including waiver services.
MSHO	Medicare cost-sharing obligations. Prescription drugs not covered by Medicare. Primary services. Acute services. Long-term services, including waiver services. Behavioral health services.
* New York MAP includes several home and community-based services waiver-like services (e.g., adult day services) but the state's 1915(c) waiver program is not incorporated into MAP.	

TABLE 7. SNP-State Contracts Define Certain Medicaid Benefits Relative to Medicare		
MSHO	**Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan**	**New York MAP**
Therapy services, including physical therapy, occupational therapy, speech therapy and respiratory therapy, for medical assistance, up to the limits established in Minnesota Statutes, §256.0653 and Minnesota Rules, Part 9505.0390 and for MSHO, for Medicare, so long as the enrollee meets Medicare criteria. (Section 6)	Medicaid services after MA plan services are exhausted. Once the following MA plan services are exhausted under contractor's Advantage Plan, the Department will cover the service. 1. Inpatient hospital care after an Enrollee has exhausted their benefit limit per eligibility period or the lifetime reserve of days. (Section X)	Non-Medicare-covered home health services. Medicaid covered home health services include the provision of skilled services not covered by Medicare (e.g., physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and/or home health aide services as required by an approved plan of care. (Appendix K)

TABLE 8. Overlapping Prescription Drug Benefits are Addressed Specifically		
MSHO	**New Mexico CoLTS**	**Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan**
For MSHO, the MCO agrees to coordinate the provision of both Medicare and Medicaid drug coverage so that coverage is as seamless as possible for the enrollee. The MCO assures that their PBM will administer Medicaid drugs according to Medicaid requirements, and that Medicaid drugs are not being confused with Medicare drugs … Drugs covered under the Medicare Prescription Drug Program are not covered for enrollees who are eligible for Medicare. (Section 6)	Contractor shall coordinate the delivery of the pharmacy benefit when Medicare Part D is the primary coverage. (Appendix A)	Medicare excluded drugs -- The MA plan is responsible for the Medicare excluded drugs and is expected to provide this coverage through the same network of providers as the Medicare Part D drugs. (Section X)

TABLE 9. Some SNP-State Contracts Explicitly Obtain Value-Added Services for Beneficiaries	
MSHO	**New Mexico CoLTS**
The MCO has chosen to waive Medicaid co-pays for MSHO community enrollees for the term of this contract. The MCO shall have a uniform policy to assure that the same amounts of co-pays for the same types of services are waived for all MSHO community enrollees. (Section 4.16)	The contractor shall provide a schedule for implementing value added benefits/services pursuant to the contractor's proposal, such as a transitional benefit, and approved by the state. … All enhanced benefits/services shall be: 1. three or more direct services and not be administrative in nature; 2. reasonably expected to be provided to 3% of the CoLTS' population in the aggregate; and 3. reported to the state in a format and frequency determined by the state. (Appendix A)

TABLE 10. Care Coordination Expectations Appear Across the Spectrum of SNP-State Contracts		
MSHO	**Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan**	**Texas Cost-Sharing**
The MCO must provide care coordination/case management services that are designed to ensure access to and to integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long-term care services, including state plan home care services under Section 6.1.14, and elderly waiver services to MSHO and MSC+ Enrollees. (Section 6.1)	PCCM services permitted under Section 1937 of the Social Security Act. MA PCCMs are responsible for the coordination of MA benefits, integrated benefits and Medicaid only benefits. (Section X)	Coordination of care means the MA dual SNP's mechanisms that promote increased coordination between the services provided by the MA dual SNP and the long-term services and supports ("LTSS") the member receives from Medicaid. (Article II)

TABLE 11. Contracts that Include Long-Term Services Include Requirements for Consumer Participation in Service Planning		
MSHO	**New Mexico CoLTS**	**New York MAP**
… the care coordinator works in partnership with the enrollee and/or authorized family members or guardians and primary care physician. … The care coordinator shall cooperate with the enrollee in developing, coordinating and, in some instances, providing supports and services identified in the enrollee's care plan and obtaining consent to the medical treatment or service. Care coordination is provided at a level of involvement based on the needs and choices made by the enrollee and/or authorized family members or guardian, and as appropriate to implement and monitor the care plan. (Section 6.1)	Have and comply with written policies and procedures for the development of the ISP, including ensuring that: the member is involved and in control, to the extent possible and desired by the member in development of the ISP; individuals whom the member wishes to participate in the planning process are included in the planning process; the member's needs are assessed and services and goods are identified to meet those needs; the member's desired level of direct management is agreed upon; and responsibilities for implementation of the ISP are identified. (Section 3.5)	… development of individual care plans, in consultation with the enrollee and her/his informal supports, specifying health care goals, the types and frequency of authorized covered services and non-covered services and supports necessary to maintain the care plan; (Section 10)

TABLE 12. Network Adequacy Provisions Take Different Approaches to Bridging Medicare and Medicaid Networks		
MSHO	**New York MAP**	**Texas Cost-Sharing**
The MCO shall provide care to enrollees through the use of an adequate number of hospitals, nursing facilities, service locations, service sites, and professional, allied and paramedical personnel for the provision of all covered services, pursuant to the following standards. (Section 6.10)	The contractor agrees to provide enrollees access to MA benefit package and MAP benefit package services as described in Appendix K-1 and K-2 of this agreement in a manner consistent with professionally recognized standards of health care and access standards required by applicable federal and state law. (Section 15)	The MA dual SNP must notify dual eligible members and other dual SNP members, via member communication materials, that information concerning Medicaid provider participation is available on the MA dual SNP's and the state's websites, and that dual eligible members may request written copies of Medicaid provider directories by contacting the Texas Medicaid enrollment broker. … The MA dual SNP must notify network providers that information concerning Medicaid provider participation is available on the MA dual SNP's and the state's websites. The MA dual SNP must provide this notice in the network provider agreement, network provider manuals, bulletins, or other contractual documents. (Section 3.08)

TABLE 13. SNP-State Contracts Include Long-Term Service Provider Standards		
MSHO	**New Mexico CoLTS**	**Texas Cost-Sharing**
The minimum age of a PCA is 18 years. The provider must be a PCA employed by or under contract with a personal care provider. Supervision of PCA is provided by a registered nurse. … personal care provider organizations must meet the standards under Minnesota rules, Part 9505.0335. … Relatives may provide personal care assistance services if they meet one of the qualifications for a PCA, and are an employee of a PCA organization. (Section 6.1)	The contractor shall have a formal process for provider education regarding the CoLTS program, the conditions of participation in the program and the provider's responsibilities to the contractor and its members. The state shall be provided documentation upon request that such provider education is being conducted. (Section 3.6)	… provide training to its network providers regarding Medicaid LTSS so that they may help dual eligible members and other dual SNP members receive needed LTSS that are not covered by Medicare. The MA dual SNP will inform network providers of the Medicare benefits and Medicaid LTSS available to dual eligible members, as well as Medicare and Medicaid eligibility rules. (Section 3.06)

TABLE 14. Some States Require SNPs to Submit Information that Would Otherwise be Submitted Only to CMS as Part of the Medicare Reporting Process		
MSHO	**Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan**	**Texas Cost-Sharing**
The MCO/SNP will provide a copy of its CMS approved bid to the state's actuarial firm within 30 days of final CMS approval for the purpose of assuring that the state does not duplicate payments on any provided services. The state will not directly review this information. The MCO must identify information as trade secret prior to or at the time of its submission for the state to consider classifying it as non-public, as described in Section 9.6. (Section 3.5)	Transmit the following data to the Department on the following schedule: Medicare Cost and Utilization Report -- Beginning 60 days after the first complete calendar quarter, then quarterly thereafter. (Appendix A)	… SNP will provide … a copy of the MA agreement and all attachments thereto … In addition, the MA dual SNP will also provide all amendments to the MA agreement and/or the bid pricing tool to the state point of contact within 15 business days of receiving a state request for such information. (Section 3.05)

TABLE 15. Some States Require SNPs to Submit Functional Status Information		
MSHO	**New York MAP**	**Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan**
The MCO SNP will notify the state or its actuarial firm of its restated mid-year HCC risk adjustment score and additional HCC frailty factor score. Scores will be from restated data based upon the preceding calendar year as reported by CMS. The MCO SNP will send this information to the state, or its actuaries, within 30 days of CMS making it available to the MCO. The actuarial firm may share information about the risk score with the state, but the state will not receive copies of this information. The MCO must identify this information as trade secret prior to, or at the time of its submission for the state to consider classifying it as non-public, as described in Section 9.6. (Section 3.5)	The contractor shall submit enrollee health and functional status data for each of their enrollees in the format and according to the timeframes specified by the state Department of Health (SDOH). The data shall consist of semi-annual assessment of members or any other such instrument the SDOH may request. The data shall be submitted at least semi-annually or on a more frequent basis if requested by the SDOH. (Section 18.5)	Transmit the following data to the Department on the following schedule: Member Level Risk Categories -- Beginning 60 days after the first complete calendar quarter, then quarterly thereafter. (Appendix A)

TABLE 16. States Require SNPs to Submit Quality Data that They Must Report to CMS		
MSHO	**New Mexico CoLTS**	**New York MAP**
Health Outcomes Survey-Modified (HOS-M) (PACE) Health Survey. The MCO SNP will share HOS-M survey results with the state within 30 days of receiving the results. (Section 3.5) The MCO agrees to operate ongoing PIPs that incorporate the standards and guidelines outlined by CMS with modifications as defined by the state. … The MSHO MCO may use their Medicare PIPs to meet Medicaid requirements if they are approved as required, conducted and reported at the dual eligible SNP plan level, applicable to the MSHO population enrolled, and all other requirements … are met … the MSHO SNP will provide the state with copies of PIP proposals to CMS and PIP reports submitted to CMS within 15 days of submission. (Section 7.2) MSHO SNPs will provide the state with all summary HEDIS reports involving MSHO SNP enrollees. (Section 7.7)	The contractor shall: (a) use the most current version of the Agency for Healthcare Quality and Research's CAHPS Medicaid Adult and Child Survey Instruments (most current version) to assess all members' (including dual eligibles) satisfaction as part of the HEDIS requirements and report the results of the CAHPS survey to the state. The contractor shall utilize the annual CAHPS results in the contractor's internal quality improvement (QI) program by using areas of decreased satisfaction as areas for targeted improvement; (b) use Medicare's HOS to assess issues related to physical and behavioral health status; (Section 3.5) … HEDIS measures required by Medicare managed care shall be included in the state's defined HEDIS measures. (Appendix B)	The contractor agrees to conduct PIPs and to measure performance using standard measures required by CMS, and to report results to CMS and SDOH, if required by CMS. Standard measures may include: • Health Plan Employer Data and Information Set (HEDIS); • Consumer Assessment of Health Plan Survey (CAHPS); and • Health Outcomes Survey (HOS). (Section 16.3)

TABLE 17. States Supplement Federal Requirements with a Focus on Care Coordination and Long-Term Services		
MSHO	**New Mexico CoLTS**	**New York MAP**
The MCO shall collaborate with the state and other MCOs to promote care coordination and case management efforts and measure its effectiveness through an intervention on a mutually agreed upon topic by the state, the MCO and the other MCOs. (Section 7.8)	Develop and comply with written quality management/QI policies and procedures to address the following requirements: … (i) continuity and coordination of services; … (k) service coordination protocols for Individuals with Special Health Care Needs (ISHCN) that reflect their comprehensive needs and service plan priorities, including coordination and integration of home and community-based waiver services, if the ISHCN member is authorized to receive the state's 1915(c) waiver services; and (Section 3.5)	The contractor agrees to participate with SDOH in the development and implementation of quality indicators and standards specific to the long-term care services furnished to enrollees, pursuant to the terms of this agreement. (Section 16.4)

TABLE 18. Grievance and Appeal Provisions Reflect the Primary Orientation of State Programs	
MSHO	**New Mexico CoLTS**
The MCO must have a grievance system in place that includes a grievance process, an appeal process, and access to the state fair hearing system. For MSHO this system must include a Medicare process for Medicare-covered services and a Medicaid process, and MSHO enrollees shall have the right to choose which or both processes to pursue. (Section 8.1)	The contractor shall: … name a specific individual designated as the contractor's Medicaid Member Grievance Coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action; (Section 3.10)

TABLE 19. SNP-State Contracts Contain a Few Targeted Financial Incentives Beyond the Rates Themselves	
MSHO	**New Mexico CoLTS**
The MCO shall participate in a dental access initiative whereby the MCO agrees to incent designated dentists to provide increased dental services for medical assistance in accordance with the following … MCOs participating in MSHO … will participate in the Annual Comprehensive Elder Health Evaluation clinical incentive program, a provider-based financial incentive program to facilitate an annual comprehensive preventive geriatric care evaluation for enrollees. (Section 7.13)	Performance incentives and sanctions. The state may provide incentives to the contractor that receives exceptional grading during the procurement process and for ongoing performance under the agreement for quality assurance standards, performance indicators, enrollment processing, fiscal solvency, access standards, encounter data submission, reporting requirements, third party liability collections and marketing plan requirements as determined by the state by automatically assigning a greater number of members to the contractor determined by the state to warrant greater assignments of such Medicaid recipients. (Section 6.1)

Issue Briefs on Special Needs Plans

A total of three Issue Briefs are available from the Office of Disability, Aging and Long-Term Care on this subject:

- **Federal Authority for Medicare Special Needs Plans and Their Relationship to State Medicaid Programs**
  [http://aspe.hhs.gov/daltcp/reports/2009/leghist.htm] Posted April 2009

- **State Purchasing Strategies Drive State Contracts with Medicare Special Needs Plans**
  [http://aspe.hhs.gov/daltcp/reports/2009/stpur.htm] Posted June 2010

- **Medicaid Contracts with Medicare Special Needs Plans Reflect Diverse State Approaches to Dually Eligible Beneficiaries**
  [http://aspe.hhs.gov/daltcp/reports/2009/SNPdual.htm] Posted June 2010

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
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200 Independence Avenue, S.W.
Washington, D.C. 20201
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