313 – CERTIFICATION OF MEDICARE ADVANTAGE PLANS SERVING DUAL ELIGIBLE MEDICARE – AHCCCS MEMBERS

EFFECTIVE DATE: 11/01/12, 06/01/15

REVISION DATE: 05/12/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care, ALTCS/EPD, Contractors pursuing and becoming Medicare Advantage/Prescription Drug/Special Needs Plans (MA/PD/SNP – hereafter MA Plan), serving dual eligible Medicaid and Medicare members. This Policy outlines the steps necessary to gain Medicare Advantage state certification by AHCCCS and the ongoing requirements to stay certified.

State certification is required as part of the CMS Medicare Advantage application. Under Arizona State Law, certification of Contractors serving persons who are eligible for Medicaid, including persons eligible for both Medicare and Medicaid (dual eligible members), can be completed by AHCCCS or through state licensure by the Arizona Department of Insurance (DOI).

Contractors serving dual eligible members can choose to be licensed by DOI, rather than certified by AHCCCS, if desired. However, if a Contractor does serve more than dually eligible Medicare and Medicaid members under its Medicare Plan, the Contractor is required to obtain certification by DOI and not AHCCCS. Also, Contractors that are applying to become stand-alone Prescription Drug Plans (PDPs) shall apply for certification with the DOI. For current AHCCCS Contractors who have a MA Plan that serves members enrolled in the Arizona Long Term Care System Developmentally Disabled program, certification can be extended to include this population.

AHCCCS will only provide certification to Contractors if they are currently a Medicaid Contractor in that same Geographic Service Area (GSA). However, due to the timing of the MA Plan application process, AHCCCS may provide a conditional certification that would allow an Offeror to start the process of becoming an MA Plan during the AHCCCS bid process for a new contracting cycle. The certification would be conditional upon being awarded a contract in that GSA for the new contracting period. Conditional approval in a particular GSA will be revoked if the Offeror is not awarded a contract in that GSA. Likewise, conditional approval will be made final in a particular GSA if the Offeror is awarded a contract in that GSA.

II. DEFINITIONS

DUAL ELIGIBLE MEMBER (FOR PURPOSES OF THIS POLICY)	A member enrolled with an AHCCCS Contractor for Medicaid services who is also a Medicare beneficiary. These persons are considered full *dual* eligible members. A full dual eligible member does not include persons who are members of the Medicare Cost Sharing populations: Qualified Medicare Beneficiary only (QMB only), Specified Low-income Medicare Beneficiary only (SLMB only) or Qualified Individual-1 (QI-1).
EQUITY PER MEMBER	Net assets that are not designated or restricted for specific purposes divided by the number of Medicare Advantage Dual Eligible Members. Refer to the ACOM Policy 305 for further clarification.
MEDICARE ADVANTAGE PLAN	An organization that provides Medicare services to Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act.
MEDICARE ADVANTAGE-PRESCRIPTION DRUG/SPECIAL NEEDS PLAN (MA-PD/SNP)	An organization that provides the full Medicare benefit, including prescription drugs, to a very specific group of Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act. Specific groups served may include members eligible for Medicare and Medicaid (dual eligibles) and/or members residing in nursing facilities.
PERFORMANCE BOND	In general, a performance bond is an instrument that provides a financial guarantee in an amount of one month's capitation or an established amount per enrolled member.

III. POLICY

A. CONTRACTOR RESPONSIBILITIES

Contractors pursuing certification as an MA Plan serving only dual eligible members should submit the CMS State Certification Request form to the Division of Health Care Management (DHCM), Medicare Administrator, at least 30 days prior to the date the

certification is required to be sent to the Center for Medicare and Medicaid Services (CMS). The State Certification Request form can be obtained from the Medicare Advantage application on the CMS website at www.cms.gov.

In addition to the State Certification Request, Contractors shall submit the following in narrative form:

1. Timing of start-up,

2. GSA that certification is being requested for,

3. Projected enrollment at start up and at the end of year one by GSA,

4. Projected amount and description of how equity per member requirements will be met initially and ongoing,

5. Projected amount, and description of how performance bond requirements will be met initially and ongoing. Refer to ACOM Policy 305 for performance bond requirements,

6. Statement of understanding regarding ongoing monitoring and reporting.

B. AHCCCS RESPONSIBILITIES

1. Within two weeks of receipt of the State Certification Request, DHCM will notify the plan of the specific financial viability requirements and/or determine if additional information is necessary to approve the request.

2. Prior to the approval, DHCM will verify that the plan will be able to comply with the requirements by obtaining a specific plan of action addressing how the standards will be met.

3. Upon review and acceptance of the plan of action noted in number 2 above, DHCM will forward a recommendation and the Certification Request to the AHCCCS Office of the Director for final signature and then back to the Contractor to be sent to CMS to continue the application process.

C. FINANCIAL VIABILITY STANDARDS AND REPORTING

In order to receive certification, the Contractor is required to be in compliance with current financial viability, claims, and administrative standards per the AHCCCS contract.

1. Performance Bond - AHCCCS requires that the Contractor obtain and maintain a performance bond specifically for the purpose of the MA Plan in accordance with ACOM Policy 305.

2. Equity per Member - AHCCCS requires that the Contractor maintain equity per MA Dual Eligible Member in accordance with ACOM Policy 305.

3. Ongoing Monitoring - The Contractor is required to self-monitor their compliance with the equity per member and performance bond requirements and to report to AHCCCS when approaching non-compliance along with a corrective action plan. AHCCCS reserves the right to investigate issues brought to the agency's attention related to the MA Plan.

4. Financial Reporting - The Contractor will be required to submit quarterly financial statements and an annual audit report and supplemental financial schedules reporting on the MA Plan line of business separately.

The Contractor shall report financial data to AHCCCS using the appropriate AHCCCS Financial Reporting Guide for the line of business to which the MA Plan is related.

IV. REFERENCE

- Acute Care Contract, Section D
- ALTCS/EPD Contract, Section D
- ACOM Policy 305
- §1876 of the Social Security Act
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- AHCCCS Financial Reporting Guide for ALTCS Program Contractors
- www.cms.gov