MEDICARE ADVANTAGE SPECIAL NEEDS PLANS: A BENEFICIARY PERSPECTIVE

Coordinating Medicare and Medicaid Services for Dual Eligibles: Different Models that Link State Medicaid Programs with Medicare Advantage Special Needs Plans

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Coordinating Medicare and Medicaid Services for Dual Eligibles: Different Models that Link State Medicaid Programs With Medicare Advantage Special Needs Plans

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Abstract: Medicare Advantage Special Needs Plans (SNPs), authorized by the Medicare Modernization Act of 2003, offer an unprecedented opportunity to develop new models of care for the seven million Americans who are eligible for both Medicare and Medicaid benefits (dual eligibles). SNPs, which may limit enrollment to Medicare beneficiaries who are dual eligibles and voluntarily choose to enroll in the SNP, have the potential to coordinate Medicare benefits with state-administered Medicaid benefits. A number of states are already working with SNPs to develop coordinated health care delivery programs, ranging from initiatives to simply better coordinate Medicare and Medicaid benefits, to programs that more fully integrate the financing and delivery of services in health plans. Three potential models a state might use to coordinate Medicaid with Medicare, utilizing SNPs, are described in this brief. The three are not mutually exclusive. First is a voluntary Medicaid program that permits a dual-eligible beneficiary to opt to enroll in a single managed care organization (MCO) that receives capitation payments to deliver both Medicaid and Medicare services to the individual. Next is a mandatory Medicaid program in which the dual-eligible beneficiary is required to enroll in a Medicaid MCO, even as the person retains the choice in Medicare whether to participate in a capitated program. Finally is an administrative services organization (ASO) approach in which Medicaid retains an administrative vendor to coordinate the delivery of Medicaid services with the SNP(s) operating in the state. This issue brief also provides practical guidance on contractual issues important to state Medicaid agencies, some advantages and disadvantages of each of the three models, and environmental factors that should influence the choice of models and the program's ultimate success.

Introduction

Medicare Advantage Special Needs Plans (SNPs), authorized by the Medicare Modernization Act of 2003 (MMA), offer an unprecedented opportunity to improve the coordination of Medicare and Medicaid benefits for individuals who are eligible for both programs (dual eligibles). SNPs, a new type of Medicare Advantage plan, are described in a companion Issue Brief entitled *Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer*. SNPs may target the dual-eligible population and partner with state-administered Medicaid programs to

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more seamlessly provide dual eligibles with a comprehensive package of acute care and long-term supports and services that are delivered in a coordinated way. With improved care coordination, unnecessary, inappropriate, and inefficient care might be averted, and higher quality beneficiary outcomes should result.

Federal law gives Medicare beneficiaries the freedom to choose the institution, agency, or individual to provide their Medicare benefits.[1] This Medicare "freedom of choice" provision enables dual eligibles to freely choose how they receive their Medicare benefits: to receive services in a Medicare fee-for-service delivery model, or instead to choose to enroll in a Medicare managed care organization (MCO), which could be a SNP or a regular Medicare Advantage plan. Coordinating a dual eligible's Medicaid and Medicare benefits theoretically is best accomplished if there is an overall system of care that coordinates the full array of Medicare and Medicaid services for the person. Because neither the Medicare program, nor the Medicaid program, is positioned to coordinate all these services *across* the programs, one mechanism to coordinate the full array of services would be achieved if a dual-eligible beneficiary enrolled, for both programs, in an organization that was responsible for the financing and delivery of all Medicare and Medicaid services. A SNP could be this entity. Yet this outcome is achieved only when the dual-eligible beneficiary sees a legitimate advantage to choose to enroll in a SNP for his/her Medicare benefits, and this SNP also has a formal relationship (of some form) with the dual eligible's state Medicaid program through which the dual eligible receives his/her Medicaid benefits.

It should also be clear that simply organizing the delivery and financing at a single entity like a SNP is not, by itself, optimal. To serve the dual-eligible beneficiary's individual needs, the SNP would need to actively and effectively *coordinate* the two programs' benefits to achieve the optimal outcomes in access, quality, satisfaction, and efficiency. Therefore, in designing coordinated Medicare-Medicaid programs, SNPs and states should have a shared interest in structuring a given program in such a way that: a) coordination of care at the individual level is promoted, b) voluntarily enrolling in a SNP for Medicare benefits is seen and experienced by dual eligibles to be desirable, and c) enrollment in the *same* health plan for both Medicare and Medicaid benefits is seen to offer clear advantages to beneficiaries.

This Issue Brief will present three different models that states might utilize to link Medicaid programs with SNPs to promote a coordinated approach to care delivery. It includes practical guidance on contractual issues important to state Medicaid agencies in implementing each model. Selected advantages and disadvantages of each model will be discussed, as well as environmental factors that may influence a state's choice of models and the program's ultimate success.

Background

In general, dual eligibles have not been enrolled in the large, traditional capitated Medicaid managed care programs for acute services.[2] This population has been carved out of Medicaid managed care programs in part because the physician who is ordering a dual-eligible beneficiary's various services and admitting the beneficiary to a hospital or nursing home typically is paid through Part B of the Medicare program, so that a Medicaid MCO cannot easily manage or integrate these Medicare-funded physician services into the beneficiary's overall

Medicaid managed care treatment plan. Dual eligibles also have been carved out of traditional Medicaid managed care programs because Medicaid-funded long-term care services, such as nursing home care, generally have not been capitated by Medicaid. However, long-term care is by far the largest expenditure by dual eligibles. Two-thirds of the Medicaid enrollees who use long-term care services are dual eligibles, and (following the advent of Medicare Part D, which moved prescription drugs from Medicaid to Medicare) 84 percent of Medicaid spending for dual eligibles is for long-term care.[3]

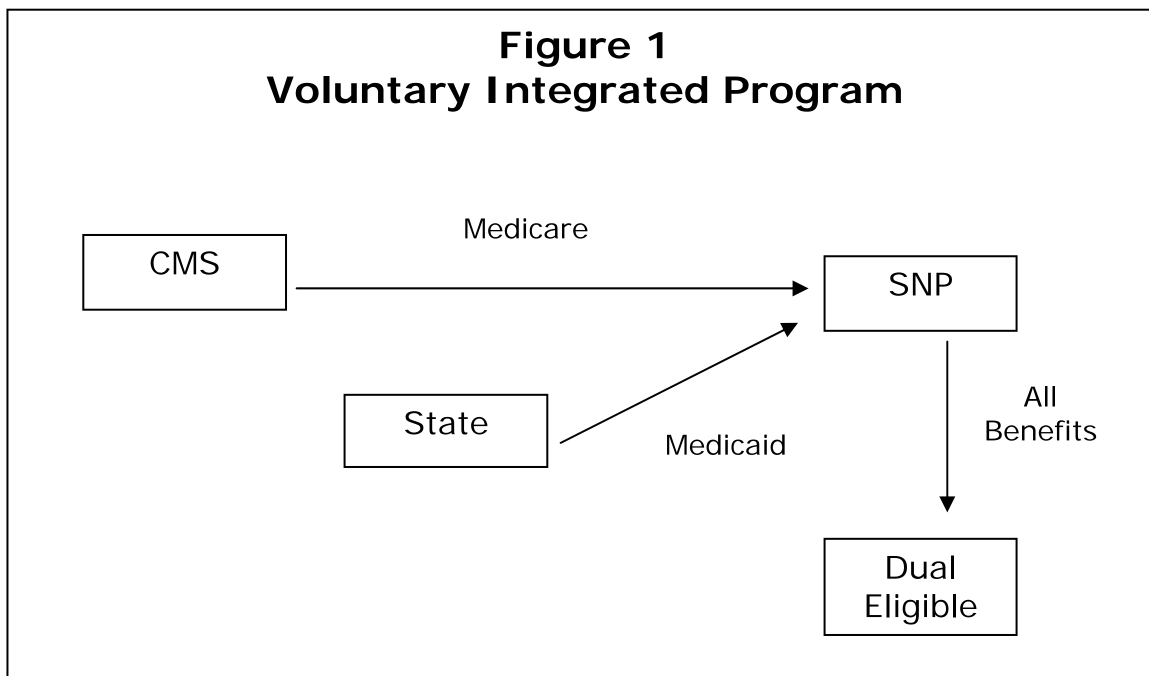
Prior to enactment of the MMA, only a few coordinated models of care for dual eligibles were in existence. These models included numerous small sites, in several regions, for Programs for All-Inclusive Care for the Elderly (PACE), as well as voluntary Medicaid managed care programs in states such as Minnesota and Wisconsin, and mandatory Medicaid managed care programs in Arizona and a region of Texas.

Three Models

Model 1: Voluntary[4] Integrated Program

In this model, a dual-eligible beneficiary who voluntarily chooses to enroll in a SNP for his/her Medicare benefits also would voluntarily enroll in the same health plan as a Medicaid MCO for his/her Medicaid benefits. Thus, the basic model would involve a single MCO, holding one capitated contract with the state Medicaid agency to deliver Medicaid services and holding a separate capitated contract with the Centers for Medicare and Medicaid Services (CMS) (as a SNP) to deliver Medicare services (for a second capitation payment).

Because a single organization would have the responsibility, and financial risk, for the dual-eligible beneficiary's benefits in both programs, incentives exist for the care to be coordinated in a way that promotes prevention and other positive outcomes. Figure 1 illustrates this model.



Minnesota Senior Health Options (MSHO), begun in 1997, is an example of a voluntary program for dual eligibles.[5] All participating MSHO plans became SNPs. Up to now, the MCOs have received a single combined capitated payment for each beneficiary, calculated using a PACE-like methodology.[6] Massachusetts Senior Care Options, implemented in 2004, is another voluntary program that has used PACE-like capitation rates and is open to beneficiaries who enroll in the same health plan for their Medicare and Medicaid services.

Both the Minnesota and Massachusetts programs are now in transitional stages, as the Medicare payment waivers that undergirded both programs are expiring and they are moving into a SNP-based structural model for payment and benefit design. The new model in Minnesota and Massachusetts will be a voluntary integrated program that could be replicated in other states and markets; other states are already considering this and are at various stages of planning and implementation. Other states offering a version of this model include Wisconsin, New York, and Washington.

On the Medicare side, Model 1 is premised on an arrangement in which the MCO would hold a Medicare Advantage SNP contract. The MCO would be responsible for delivering all Medicare-funded services, including Part D prescription drugs, and any supplemental Medicare benefits approved and required by CMS during the SNP bidding process. The rate structure would mirror the rate setting system for Medicare Advantage as a whole, which is migrating to a risk-adjusted payment system that takes a number of factors into account in predicting the need for Medicare services.

On the Medicaid side, the same MCO would need to secure a capitated contract with the state Medicaid agency. The Medicaid contract would include a capitated per person per month payment to the MCO for Medicaid-funded services, and the state's Medicaid capitation payment system would take certain state-specified risk adjustment factors into account, ranging from simple factors (age, gender, nursing-facility level of care or not) to more complex factors (for example, Massachusetts chose to pay a higher rate for someone with a dementia diagnosis, and Minnesota chose to remove the risk to MCOs for an individual in a very-long nursing home stay because of the difficulty an MCO would have in managing or transitioning that resident's care to a less-expensive community setting).

Working with the Center for Health Care Strategies, Inc. (CHCS) and others, CMS is actively developing policies and procedures across Medicare and Medicaid to improve the viability of this type of integrated voluntary program, while attempting to retain the PACE-like features that Minnesota, Wisconsin, and Massachusetts were able to deploy under their expiring Medicare waivers.[7] For example, CMS is actively working with CHCS and a number of states and interested parties to develop mechanisms that address and coordinate, across Medicare and Medicaid, functions such as program marketing, enrollment, service coordination, financing, data management and sharing, Medicare supplemental benefits, coordination of benefits, and quality assurance.[8]

Because participation in these programs is entirely voluntary for dual eligibles, enrollment and "scale" is dependent on both a good model of care and good outreach to prospective dual-eligible

enrollees. For a successful program that offers optimal access, quality, and coordination of services across Medicare and Medicaid, the program should be designed so that it can be "taken to scale" in the given state in order to achieve a large, diverse enrollment, an extensive provider network, and operational economies of scale. In moving forward with a voluntary program under Model 1, a state typically would weigh the likelihood of moving to scale with an adequate enrollment against the state's administrative challenges of continuing to operate its regular Medicaid fee-for-service program for those dual eligibles who choose not to enroll in the voluntary program. Thus, the scale of the program, and the implications of a small or geographically limited program, should be taken into account in moving forward with Model 1 in a given state. Also, in order to minimize the impact of selection bias in a voluntary program, the program must have a well-conceived rate-setting system that takes the appropriate risk factors into account. The optimal rate-setting system would encourage enrollment from across all acuity levels of dual eligibles (those who are "healthy" and use relatively few Medicaid services, nursing home residents, and those requiring Medicaid community-based long-term care services) without penalizing or rewarding MCOs based on their specific enrollment mix. SNPs should consider a joint, approved, coordinated marketing effort with Medicaid that targets each subpopulation of dual eligibles.

Assuming it is the state's goal to encourage dual eligibles to enroll in this coordinated system of care, it should design the program to promote objectives that dual eligibles would value: promotion of community-based care as an alternative to institutions; active care coordination; promotion of self-direction; etc. The program should include a full array of community-based long-term care supports and services, as well as non-traditional services that could help an individual remain in the community (e.g., home renovations, a one-time purchase of special equipment, transition resources to move from an institution back to the community). The flexibility of capitation payments to secure goods and services that are *outside* the constraints of traditional Medicaid fee-for-service programs, and an MCO's willingness to use this flexibility to individualize plans of care and services for dual eligibles, is key to the effectiveness of these programs. Some beneficiaries are also likely to want the option of self-directed personal care services. Care coordination must be structured to cut across traditional Medicare-Medicaid service boundaries to enable the services in the two programs to be coordinated and delivered in the best overall way (i.e., good health outcomes, high consumer satisfaction, cost-effectiveness) to reduce avoidable hospital stays (thereby saving Medicare funds) avoidable long-term nursing home stays (thereby saving Medicaid funds), and so on. Where appropriate care requires, services from one program should be readily substituted for services from the other program; utilizing Medicaid personal care, for example, may be appropriate as an alternative to (or in addition to) Medicare home health. A well-run program should reduce unnecessarily long lengths of stay, provide more effective hospital and nursing home discharge services, and encourage appropriate and sufficient person-centered community-based care.

Transparency in pricing will be important to the state. Because the state is not a party to the Medicare bidding process, at a minimum the state should request publicly available information on the SNP's bid negotiations with CMS. A better practice is for the state to require a SNP's bidding information and Medicare supplemental benefit information as a condition of entering a contract with the state.

With the "bundled" package of Medicare and Medicaid services offered by these integrated programs, information on the delivery of Medicare services also should be sought by states as a condition of a Medicaid contract. Utilization data will also be useful for quality assurance and to inform rate setting. Care management is likely to be driven more by medical management than revenue management in these capitated programs.

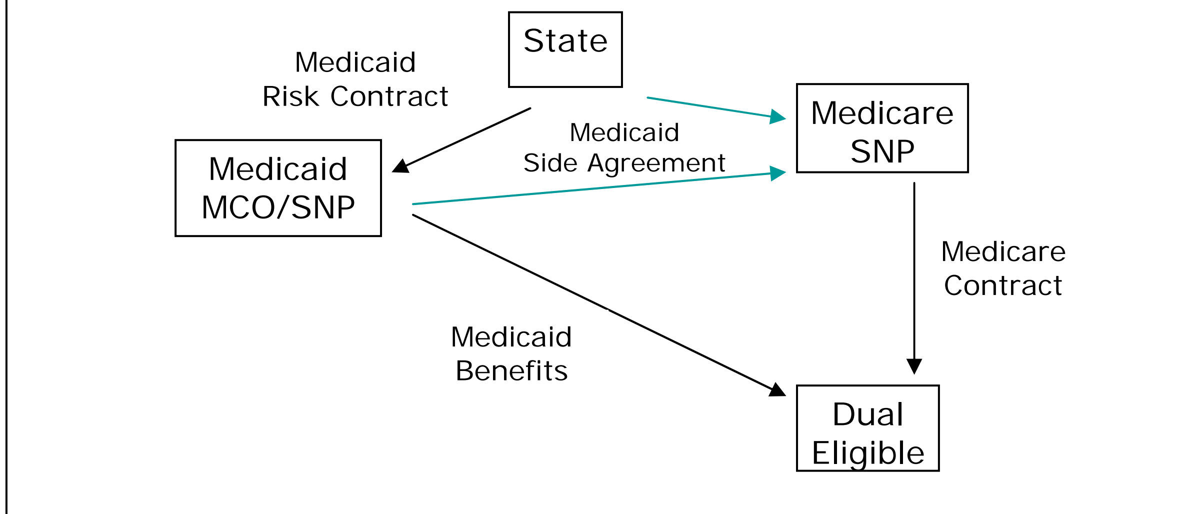
It will be important to obtain periodic feedback from beneficiaries on satisfaction with the integrated program, most likely through a survey. The state may also require a consumer advisory board to address the concerns of beneficiaries. SNPs and states should pursue a coordinated process for registering and resolving appeals and grievances from beneficiaries.

Model 2: Mandatory Program, with Potential Side Agreements

This model involves a program in which a dual eligible would be required to enroll in a capitated Medicaid managed care program with an MCO, even as the person retains the choice in Medicare whether to participate in a capitated program. This model now exists in Arizona and Texas, and CMS has approved the necessary waivers for Florida's Medicaid program to proceed as well. States pursuing Model 2 typically require that as a condition of receiving a contract with the state, an MCO also must be approved in the state as a SNP, thereby retaining the possibility that a single entity might serve as both the dual-eligible beneficiary's Medicaid MCO and as his/her Medicare SNP.

For Medicare benefits, of course, a dual-eligible beneficiary still retains his/her freedom of choice. Thus, there are three possible outcomes if a state pursues the mandatory Medicaid program described in Model 2: first, that the dual-eligible beneficiary remains in Medicare fee-for-service, in which case the person's Medicaid MCO must coordinate the contractual Medicaid benefits with the enrollee's Medicare benefit providers; second, that the dual-eligible beneficiary enrolls in the same MCO for both Medicare and Medicaid benefits, by choosing to enroll in the SNP that also serves as the person's Medicaid MCO; or third, that the dual-eligible beneficiary enrolls in two separate MCOs, in that he/she selects a Medicare Advantage plan (perhaps even a SNP) that is not the same health plan as the person's Medicaid MCO, in which case the two separate health plans would need to coordinate with one other. Clearly, the ideal scenario in this mandatory program model is enrollment in the same high-quality health plan for both Medicare and Medicaid benefits, in which case the outcome resembles Model 1.

As shown in Figure 2, though, even when the dual-eligible beneficiary is *not* enrolled in the same health plan, coordination of care and benefits still could occur in a manner that improves quality, access, and coordination for the dual eligible enrollee. For example, as depicted in Figure 2, the state could establish a separate "side agreement" with Medicare SNPs operating in the state, and failing that the various health plans could have side agreements among themselves, to engage in electronic health record data sharing, service data sharing, coordination about discharges, alerts about changes in enrollee health status or other risk factors, coordination of benefits, and many other elements. This kind of side agreement is not prevalent in the existing models, but it would represent a vast improvement over the current mandatory models.



These side agreements would establish arrangements for coordinating certain information as a matter of contract. For example, a Medicaid MCO ("Plan A") would want to know when a beneficiary is admitted to a hospital for a Medicare-covered service. Plan A could have a contract with each SNP in the state in which the SNP ("Plan B") agrees to provide this information to Plan A. Similarly, Plan B would want to know when the beneficiary is admitted to a nursing home for a Medicaid-covered stay, because it might want to actively provide supports in the nursing facility (such as physician assistant or nursing practitioner services) to avoid unnecessary Medicare-covered hospital admissions from the nursing facility. This is especially true when Plan B is unaware that the person was admitted to the nursing home in the first place, because the admission initially occurred without a prior Medicare hospitalization, such as a nursing facility admission related to dementia. Thus, the side agreement also could provide that Plan A (Medicaid) informs Plan B (Medicare) of all Medicaid-financed nursing home admissions involving a beneficiary common to both plans.

The side agreements ideally would be established directly by the state, in which the state would compel each Medicaid-contracted MCO to provide certain data and information to the state that the state then would make available to SNPs through a side agreement that includes the necessary patient privacy protections. The state also might seek to enter into mutually advantageous contracts with non-Medicaid contracted health plans operating as approved SNPs in the state. Once the side agreements are created in this manner, the state could act as a clearinghouse between all the Medicaid-contracting MCOs and all the Medicare Advantage SNPs operating in the state to share data on enrollees common to each set of health plans. This could be structured in a manner that does not violate any patient confidentiality rules. The state then could share clinical and claims information through this clearinghouse. This is a means for states to design programs that link Medicaid with SNPs to improve the coordination of benefits across Medicare and Medicaid. In this way, positive health and service outcomes could be

achieved, even if the dual-eligible beneficiary is not enrolled in a single plan for both Medicare and Medicaid, provided the data sharing is sufficiently robust and timely.

A less desirable outcome is that health plans could establish these side agreements among themselves, without the state's involvement. This outcome is less desirable because the state would benefit from the Medicare-related data to design and improve its administration of Medicaid services for dual eligibles. Still, if the state is not pursuing this role, the plans could contract among themselves, and secure the necessary consents to share protected health information with one another. This way, the two health plans, one responsible for Medicaid and one responsible for Medicare for a given dual-eligible beneficiary, would be able to coordinate the services.

The side agreements could also incorporate other features, such as enrollment and care coordination policies and procedures, marketing arrangements, grievance processes for benefits common to both programs, coordination of benefit arrangements, and other elements. The agreements could include procedures for identifying and assessing needs and developing, implementing, and monitoring care plans, all with the goal of providing a seamless array of services for the dual-eligible beneficiary.

Side agreements for data sharing and coordination of benefits would be especially important. Sharing of clinical and claims data would be crucial for utilization monitoring, quality assurance, and rate setting. Data sharing would enable the plan(s) and the state to more effectively monitor access to care, the adequacy of provider networks, compliance with performance measures, the coordination of benefits to ensure the proper program delivers a given benefit, the experience with disease management programs, and financial performance. The health plan(s) and the state would also be able to begin to better understand the interrelationship between Medicare and Medicaid service provision and the extent to which efficiencies achieved by one payer can offset the costs of the other. The importance of data sharing is underscored in the February 12, 2007, letter from the National Governors' Association to federal Department of Health and Human Services Secretary Leavitt.[9]

Also in the side agreements, responsibility for payment of Medicare "cross-over claims" could be specified—i.e., Medicare Part B premiums, annual deductibles, and coinsurance for physician visits and hospital stays. Medicaid is responsible for these costs, but the state would want to consider whether to pay these expenses directly or to include funds for these payments in the beneficiary's capitation payment. The state must weigh ease of administration versus maximizing federal matching payments[10] and minimizing "clawback" payments required under the MMA.[11]

As with Model 1 (the voluntary integrated program), the health plan(s) and the state should consider instituting, through side agreements, policies and procedures for jointly addressing grievances and appeals filed by beneficiaries. A beneficiary could be denied home health, for example, because the Medicaid MCO believes that Medicare should cover it, and the SNP believes it is not a Medicare-covered service and the Medicaid MCO should cover it. A mechanism to resolving these cross-program coverage disputes, in a beneficiary-centered way, is crucial to effective programs that coordinate care.

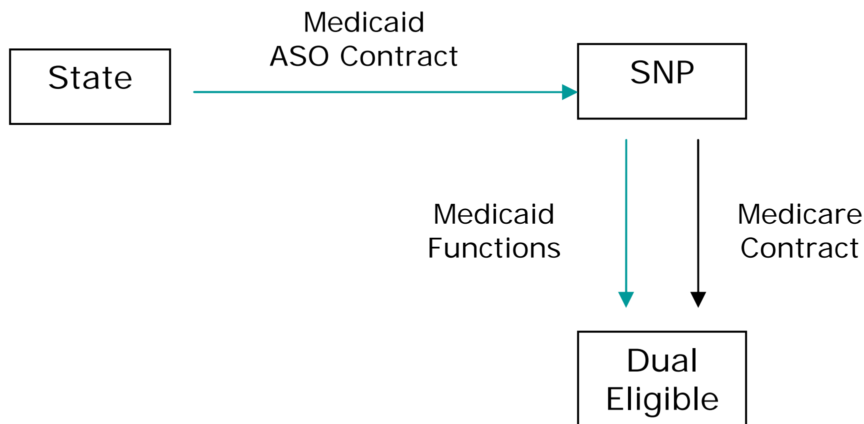
Mechanically, in order to receive the approval to operate a mandatory Medicaid managed care program, a state would need to secure a federal waiver, such as a Section 1115 federal Medicaid waiver, or a combined Section 1915(b)(c) Medicaid waiver (the 1915(b) authorizes mandatory managed care and the 1915(c) allows financing for Medicaid home- and community-based services). The new authority offered under the Deficit Reduction Act of 2005 offers an additional possibility for the delivery of home- and community-based services: adding these services under an approved Medicaid state plan without a waiver; this is now known as a Section 1915(i) program.

Arizona's mandatory program operates under a Section 1115 waiver, and the mandatory program in Texas operates under a combined Section 1915(b)(c) waiver that initially was approved in 1997. In September 2006, CMS approved a combined Section 1915(b)(c) waiver for Florida Senior Care, a third mandatory program. The program has been authorized by the Florida legislature and is scheduled for implementation in two pilot areas in 2008.[12] Several other states are now considering mandatory programs utilizing Medicaid Section 1915(b)(c) combination waivers. New Mexico has a Section 1915(b)(c) waiver combination pending approval by CMS.

Model 3: Program with ASO Arrangement

This model involves an administrative services organization (ASO) approach in which Medicaid would retain an administrative vendor to coordinate the delivery of Medicaid services with the SNP(s) operating in the state. To enhance the prospects of coordination with Medicare, the entity retained by the state to serve as an ASO could be one (or more) of the dual eligible SNPs themselves.[13] In this model, then, the state could retain the SNP(s) to *administer*, on a non-risk basis, the Medicaid benefits utilized by each dual-eligible beneficiary. Coordination across Medicaid and Medicare could occur because the same entity would be aware of, and have responsibilities for, the dual-eligible's full service array in its two separate capacities as Medicaid ASO and Medicare (see Figure 3). This approach to coordination between Medicaid and Medicare does not involve a managed care program, and it does not require a federal Medicaid waiver. Rather, because each ASO contract is purely administrative (like a fiscal agent contract or a utilization review contract), a waiver is not necessary.[14] Payment is not based on financial risk for services, but rather on an administrative fee to deliver the state's Medicaid fee-for-services benefits, through its existing provider network.

Figure 3
Program with ASO Arrangement and Benefit Wraparound



The state could execute ASO arrangements with any or all of the SNPs operating in the state. SNPs then could be made responsible for administering state Medicaid wraparound services for any dual eligibles who enroll in their SNP. The ASO arrangement would not alter existing Medicare and Medicaid benefit packages, nor would it impact the provider networks offered separately by Medicaid and the SNP. As an ASO, the SNP's role in the administration of Medicaid benefits would involve purely Medicaid administrative activities defined by the terms of the ASO contract between the entity and the state, such as approving or denying Medicaid claims for dual eligibles, paying providers on a non-risk (pass-through) basis, enrolling providers into the Medicaid fee-for-service program, reviewing and approving long-term care plans of care, etc. The entity's role in administering Medicaid would be invisible to the beneficiary, who would retain the right to choose his/her Medicaid providers, in much the same way that beneficiaries now are largely unaware of what company is retained by a given state to serve as a Medicaid claims-processing fiscal agent or a Medicaid utilization review contractor.

In this arrangement, the SNP essentially performs "back office" functions for Medicaid. Yet this arrangement likely would result in improved coordination of care for dual eligibles, because the SNP *would have a complete awareness of the Medicaid-funded services* (in its role as the entity reviewing and approving these claims). Thus, the SNP could coordinate the Medicaid benefits it is managing on behalf of the state with the Medicare benefits it is responsible for and at-risk to deliver. Moreover, under a Medicaid ASO contract, the state could delegate to the SNP whatever Medicaid-related functions it chooses to include in the contract, such as marketing, enrollment and assessment, care coordination, provider enrollment and credentialing, administration of benefits, payment of claims, management of appeals and grievances processes, and utilization review. The state would remain accountable to the beneficiaries for these administrative functions, meaning the state would need to exercise oversight; yet the SNP could become fully aware of each dual-eligible beneficiary's complete Medicaid service array. The state would

require data sharing on all of these functions. In addition, the state might request Medicare service utilization data for dual eligibles.

Under an ASO contract, the state likely would pay the SNP an administrative "case management" fee for each Medicaid member for whom the SNP will be administering Medicaid benefits. The administrative fee could be an agreed-upon dollar amount per member per month, or it could be based on a percentage of Medicaid dollars administered by the organization. The state pays Medicaid claims on a fee-for-service basis; there are no capitated payments involved. In this sense, the ASO model is much like the primary care case management model in Medicaid, whereby a provider is paid an administrative fee to coordinate services, but is not at financial risk.

This model could work well for a state with little or no experience with capitated Medicaid managed care. It could also be a good initial step (or transitional plan) for states considering whether to eventually pursue Model 1 or Model 2.

An ASO arrangement could be a good opportunity for a SNP with no prior experience with the state Medicaid program to begin doing business in the state. The SNP would gain knowledge about the Medicaid program, the nursing home industry, the state's panel of Medicaid fee-for-service providers, the availability of community-based long-term supports and services, and the infrastructure available to support expanded community-based services (e.g., housing, labor, state policies). The SNP would also be able to begin building a provider network for Medicaid beneficiaries.

One major risk in an ASO arrangement, clearly, is the inherent conflict of interest that could result. The SNP, acting as a Medicaid ASO, could authorize a vast (and potentially excessive) array of Medicaid-funded supports and services, to avoid Medicare-related expenses such as hospitalizations. Because the SNP is not at financial risk under Medicaid, excessive approval of Medicaid-covered services would not affect the SNP's bottom line. Moreover, the entity could use its knowledge gathered from Medicaid claims (both diagnoses and utilization information) to cherry-pick Medicare enrollees for its SNP. To address this issue, states should consider performance measures in ASO contracts, which could be based in part on the cost of approved plans of care.

Comparison of the Three Models

The three models discussed above vary significantly in structure, payment policy, and the extent to which Medicare and Medicaid benefits are coordinated. Figure 4 summarizes the importance of SNP-state efforts to coordinate program design and administration for each of these models.

FIGURE 4
Models Linking State Medicaid Programs with Medicare Advantage Special Needs Plans: The Importance of Coordinating Program Design and Administration

Program Component	**Model 1** Voluntary Integrated Program	**Model 2** Mandatory Program with Potential Side Agreements	**Model 3** ASO Arrangement and Benefit Wraparound
Coordinated Marketing	*Very Important*	*Very Important*	*Not Required*
Coordinated Enrollment and Assessment	*Very Important*	*Very Important*	*Not Required*
Care Coordination	*Very Important*	*Very Important*	*Not Required*
Transparency in Pricing	*Very Important*	*Very Important*	*Not Important (fee-for-service)*
Utilization Monitoring	*Very Important*	*Very Important*	*Not Required (State has claims data for monitoring)*
Data Sharing	*Very Important*	*Very Important*	*Not Required (State has claims data for monitoring)*
Coordinated Appeals and Grievances	*Very Important*	*Very Important*	*Not Required*
Payment of Cross-Over Claims	*Less Important*	*Very Important (must decide if state or SNP pays claims)*	*Not Important (Medicaid pays through fee-for-service)*
Coordinated Beneficiary Satisfaction Surveys	*Very Important*	*Very Important*	*Not Important*

Factors Influencing Adoption and Success of the Three Models

A number of factors will influence the choice of models. States that have managed care experience or a preference for managed care as a vehicle for care will be more likely to pursue Model 1 or Model 2. However, ease of implementation is also a factor. For example, Model 2 requires the approval of a mandatory Medicaid managed care waiver by CMS, which can be a long and arduous process. Model 1 requires CMS approval of a voluntary capitation program for Medicaid (usually under 1915(a)), but this does not involve a waiver. On the other hand, Model 3 requires no federal waiver or approval process, beyond the approval of the administrative vendor contracts.

From the perspective of a SNP, the optimal model might be Model 1, in spite of its small scale, if managed Medicare is not well-established in the state and providers and beneficiaries are strong

proponents of Medicare fee-for-service. On the other hand, if managed Medicare is trusted and established in the state, then Model 2 might be preferable for a SNP, because dual eligibles might be more likely to voluntarily enroll in a Medicare Advantage plan if they are familiar with and trust managed care; the opportunity for greater scale (on the Medicaid side, with a mandatory program) might overcome the risk of coordination challenges across plans.

The choice of model and ease of implementation will be impacted by the environment within the state. Budgetary pressures and the extent to which the governor, legislature, and advocates are pushing Medicaid reform and managed care will have a direct influence on model choice and paving the way for implementation. Prior successful collaboration on program development by the Medicaid, aging, and disabilities agencies is also important.

The long-term success of Model 1 and Model 2 will be dependent on development of a sound, risk-adjusted methodology for setting Medicaid capitated payment rates.

Because it is a voluntary program, Model 1 might result in a relatively small program. Projected enrollment will be a major factor in a SNP's decision to partner with the state, as enrollment will directly impact provider participation, market penetration, operating efficiencies, and margins.

Enrollment will affect the success of Model 1 and Model 2 in another way. If dual eligibles, in exercising their Medicare "freedom of choice," choose to enroll in either fee-for-service Medicare or a SNP not affiliated with their Medicaid MCO, they must be served separately from beneficiaries who choose to participate in managed care. Under Model 1, this means that enrollment in the voluntary program is directly related to the attractiveness of the Medicare Advantage SNPs in the Medicare market, as a strong alternative to Medicare fee-for-service. Under Model 2, the individual will be required to enroll in the state's Medicaid managed care program, but there may be no easy coordination of Medicare-Medicaid benefits. Clearly, using effective marketing campaigns and enrollment systems will be critical to the success of these programs. But marketing and enrollment techniques can only go so far. Beneficiaries must see *and experience* a clear benefit in the services offered by these programs. Side agreements to enhance care coordination would improve the effectiveness under Model 2.

Model 3 is an option for states with limited experience with, or interest in, capitated Medicaid managed care. States where few SNPs operate or SNPs are not geographically dispersed across the state are also good candidates for this model. In addition, states with existing ASO relationships might consider Model 3. Model 3 also is best for states in which the Medicaid *matching rate for services and the Medicaid matching rate for administration are identical or almost the same*, because in Model 3 alone the ASO is paid under the state's administrative matching rate (typically 50 percent federal financing for all states), not the state's service matching rate (often higher than 50 percent federal financing for poorer states) so in a wealthier state, with a 50 percent matching rate on the service side, the choice to use an ASO does not result in a shift to state funds.

Data sharing arrangements will be important for all three models, but especially for Model 1 and Model 2. It will be crucial for states to begin to document efficiencies achieved in both service

provision and costs—as well as improved outcomes for beneficiaries—through the coordination of Medicare and Medicaid services.

Additional Thoughts

Medicare Advantage SNPs offer an unprecedented opportunity for states to develop Medicaid programs that coordinate Medicaid benefits with the Medicare benefits delivered by SNPs. Ideally, this would provide more coordinated, community-based care and reduce unnecessary hospitalizations and nursing home stays. Yet to date, as described in our companion Issue Brief,[15] most of the 320 SNPs approved by CMS to serve dual eligibles are providing Medicare services only. Many state Medicaid agencies are actively seeking to join with SNPs to provide coordinated Medicare and Medicaid benefits to dual eligibles. This issue brief describes three potential models, the benefits of each, and the challenges SNPs and states will face in implementation. It will be important to monitor the experience with these models to determine the impact on the cost and quality of care for dual eligibles, as well as the future of coordinated Medicare-Medicaid service models.

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[1] §1802 of the Social Security Act.

[2] For example, see: Neva Kaye, *Medicaid Managed Care: A Guide for States*, National Association for State Health Policy, Fifth Edition, May 2001; Robert Hurley and Michael McCue, *Partnership Pays: Making Medicaid Managed Care Work in a Turbulent Environment*, Center for Health Care Strategies, May 2000.

[3] Anna Sommers, Mindy Cohen, and Molly O'Malley, *Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns*. Kaiser Commission on Medicaid and the Uninsured, November 2006.

[4] Because a beneficiary's option to participate in managed care is always voluntary in Medicare, the distinction between "voluntary" and "mandatory" in this report designates the nature of the beneficiary's participation in Medicaid managed care.

[5] Minnesota Senior Health Options (MSHO) began prior to enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. It was authorized by a type of Medicare payment waiver (Section 222) that CMS elected to discontinue once the authority for SNPs came into existence. Minnesota, as well as Massachusetts and Wisconsin, utilized these expiring Medicare waivers to create integrated programs for dual eligibles.

[6] PACE providers historically received a monthly capitation rate from Medicare that was equal to the rate for Medicare risk plans (the forerunner to Medicare Advantage plans) multiplied by a uniform adjuster to reflect the frailty of the population they served. They currently receive a blend of that frailty-adjusted rate and a risk-adjusted payment rate similar to that received by Medicare Advantage plans, and eventually will receive only the risk-adjusted rate. The Medicaid rate received by these programs is negotiated between the plan and the state.

[7] Several other states also operate, or have been approved to operate, voluntary programs. These states, New York, Washington, and Florida, did not have earlier Medicare payment waivers to launch their programs.

[8] Centers for Medicare and Medicaid Services, "Improving Access to Integrated Care for Beneficiaries Who are Dually Eligible for Medicare and Medicaid." Fact Sheet, July 27, 2006.

[9] National Governors Association, Letter to The Honorable Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, February 12, 2007. Available at http://www.nga.org/portal/site/nga/menuitem.cb6e7818b34088d18a278110501010a0/?vgnextoid=b36368325b6b0110VgnVCM1000001a01010aRCRD.

[10] The federal government's share of a state's expenditures for Medicaid is called the Federal Medical Assistance Percentage (FMAP). The FMAP is based on the state's per capita income and determined annually.

[11] States must pay monthly "clawback" payments to the federal government to help finance the Medicare Part D prescription drug benefit for dual eligibles. These payments will be phased down from about 90 percent of what states would have paid for prescription drugs for dual eligibles to about 75 percent in 2015.

[12] Links to Florida's waiver applications and legislative authorization can be found at http://ahca.myflorida.com/Medicaid/long_term_care/index.shtml.

[13] The ASO also could be an entirely unrelated entity with competencies at administrative services and coordination of care.

[14] As a result, the fees paid to the ASO would be matched at the federal government's administrative Medicaid matching rate, not the higher services matching rate available to many states. The contract itself would need to be approved by CMS, as large Medicaid administrative contracts must, but no federal Medicaid waiver would be required.

[15] *Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer.*