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Integrating Medicare and Medicaid Services Through Managed Care

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Prepared for Members and
Committees of Congress

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Summary

This report discusses efforts to improve the delivery of health and long-term care services for individuals who are dually enrolled in Medicaid and Medicare (i.e., dual eligibles), which generally includes the elderly and some individuals with disabilities. Dual eligibles are more likely than other Medicare beneficiaries to be in fair or poor health, cognitively and/or functionally impaired, and have more chronic ailments and conditions. The Medicaid and Medicare programs that provide services to dual eligibles are administered by different units of government, guided by different laws and regulations, and cover a different set of services for these individuals. These differences can lead to fragmentation and inefficiencies.

Some federal and state policymakers have tried to address these challenges and develop a coordinated and/or integrated approach to delivering Medicare and Medicaid services through managed care. The Program of All-inclusive Care for the Elderly (PACE), as well as state programs in Arizona, Massachusetts, Minnesota, New York, Texas, and Wisconsin, are some of the managed care programs discussed in this report.

Recently, the Medicare Modernization Act (P.L. 108-173) established the Medicare Special Needs Plan (SNP) option, which was intended to improve care coordination and service delivery for certain groups of Medicare beneficiaries. Under the SNP option, Medicare managed care plans are allowed to limit enrollment to certain types of beneficiaries such as dual eligibles. SNP plans may choose to better coordinate the care of dual eligibles by contracting with the state Medicaid agency to also provide Medicaid services, but SNP plans are not required to do so. It is too soon to tell the extent to which the new SNP option will actually increase participation in integrated Medicare/Medicaid managed care plans.

There are a variety of challenges in developing, enacting, and implementing integrated Medicare and Medicaid programs. The specific circumstances will vary by state, but some of the challenges have included reconciling conflicting operational requirements between Medicaid and Medicare, ensuring sufficient experience of managed care plans with the needs of dual eligibles, and addressing provider and beneficiary resistance to managed care. These and other challenges are discussed in this report.

Finally, this report describes policy considerations and legislation that have been introduced in this area during the last several sessions of Congress. Recent interest in integrated managed care suggests that the 110th Congress may consider expanding these plans to promote more efficient and cost-effective delivery of health care for dual eligibles. This report will be updated to reflect significant policy or programmatic changes at the national level.

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Introduction

This report discusses efforts to improve the delivery of health and long-term care services for nearly 7 million individuals nationwide who are enrolled in both Medicare and Medicaid, known as dual eligibles.[1] There are several subcategories of dual eligibles. Although all duals receive Medicare-covered services, some receive full Medicaid benefits and others receive only assistance with Medicare cost-sharing. This report is focused on those dual eligibles who receive both Medicare benefits and the full range of Medicaid benefits offered in their state.

Dual eligible beneficiaries are generally elderly or have significant disabilities, and are more likely than other Medicare beneficiaries to be in fair or poor health, cognitively and/or functionally impaired, and have more chronic ailments and conditions. Dual eligibles also use a disproportionate share of Medicare and Medicaid services. In 2002 (the most recent data available), dual eligibles accounted for 16% of Medicare beneficiaries, and 22% of Medicare spending.[2] For Medicaid, based on FY2003 data, dual eligibles comprised 13% of Medicaid beneficiaries, and 41% of Medicaid expenditures.[3]

The Medicare and Medicaid programs are administered by different units of government, guided by different laws and regulations, and cover a different set of services, which can lead to fragmentation, confusion, and inefficiencies in the delivery of services for dual eligibles. Medicare is federally administered by the Centers for Medicare and Medicaid Services (CMS). Medicare generally covers primary and acute care services (e.g., physician, hospital) and a limited set of long-term care services (e.g., post-acute, short-term stays in skilled nursing facilities and post-acute home health care services). Starting January 1, 2006, Medicare also began offering a voluntary prescription drug coverage under a new Part D benefit. Dual eligibles were required to switch from Medicaid to the new Part D benefit to receive their prescription drugs.[4]

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[1] CRS analysis of CMS, Medicaid Statistical Information System (MSIS) State Summary DataMart, Apr. 4, 2006.

[2] [http://www.medpac.gov/publications/congressional_reports/Jun05DataBook_Entire_report.pdf].

[3] Additional information is available in CRS Report RL32977, *Dual Eligibles: A Review of Medicaid's Role in Providing Services and Assistance*, by Karen Tritz.

[4] For additional information, see CRS Report RS21837, *Implications of the Medicare* (continued...)

Medicaid is a means-tested program, administered by each state within broad federal guidelines. Medicaid benefits include primary and acute medical services, as well as long-term care service. Within broad federal guidelines, each state may define its own package of covered medical services, resulting in considerable variation in the types of services covered across states. In addition to choosing whether a service is covered, states may also limit the amount, duration, or scope of a service, meaning that they can limit the number of hours, days, or type of coverage for a particular service. For example, a state may specify that payment for inpatient hospital services cannot exceed 40 days of coverage in a 12-month period.[5]

For dual eligibles, if a service is covered by Medicare and Medicaid, Medicare is the primary payer; Medicaid pays for services above and beyond what Medicare covers (referred to as wrap-around coverage). Medicaid may also cover some beneficiary cost-sharing associated with particular Medicare services. For Medicaid benefits that are not covered by Medicare, such as certain long-term care services, Medicaid covers the cost of these benefits unless there is another liable third-party payer. Medicaid is generally the payer of last resort. **Table 1** below briefly describes various Medicare and Medicaid services that may be covered for dual eligible individuals. A full discussion of the rules and requirements for each service type is beyond the scope of this report.

Table 1. A Comparison of Coverage Under Medicare and Medicaid for Selected Service Types

Type of Service	Coverage Under Medicare	Coverage under Medicaid (see note below)
Inpatient and outpatient hospital	Covered with limitations on the duration of inpatient hospital stays.	Mandatory. Some states limit the duration of inpatient hospital stays, and/or the number of outpatient visits.
Mental health facilities	Coverage is limited to 190 days per lifetime in a mental hospital. Also covers partial hospitalization services.	Optional. Covered by 49 states and D.C. Does not cover services for adults between ages 22 and 64 who reside in an institution for mental disease.
Nursing facility	Covered for post-hospital stays up to 100 days per benefit period.	Mandatory for ages 21 and over. Generally, states do not limit the duration of coverage.
Physician	Covered.	Mandatory. States may limit the number of visits per year.

[4] (...continued)
Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs, by Karen Tritz.

[5] For additional information, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

Type of Service	Coverage Under Medicare	Coverage under Medicaid (see note below)
Other licensed practitioners (e.g., chiropractors, psychologists)	Covered for certain types of practitioners (e.g., physician assistants, clinical social workers). Coverage may be restricted to certain types of services.	Optional. Covered by 50 states and D.C., though not all states or D.C. cover all types of practitioners.
Home health	Covered for persons who need skilled nursing care on an intermittent basis or physical, speech, and occupational therapy. In addition, the individual must be homebound.	Certain home health services are mandatory for some individuals (e.g., nursing services); others are optional (e.g., therapy). States may limit the number of visits per month, or per year.
Rehabilitation	Covered for inpatient rehabilitation facilities subject to limitations on the duration, and for comprehensive outpatient rehabilitation facilities.	Optional. Covered by 50 states and D.C. Many states use this service category to cover mental health and substance abuse services.
Therapies (physical, occupational, speech/language)	Covered, subject to limitations in the total expenditures covered in certain settings.	Optional. Covered by 39 states and D.C. Not all states may cover all types of therapies for all beneficiaries.
Hospice	Covered for individuals who are considered terminally ill (a life expectancy of six months or less).	Optional. Covered by 47 states and D.C.
Transportation	Covers ambulance services when necessary (other transportation is not available).	Mandatory. Coverage is provided for medical appointments.
Clinic	Covers some laboratory and screening services. Medicare also covers services provided by federally qualified health centers, rural health centers, and freestanding ambulatory surgical centers.	Optional. Covered by 48 states and D.C. States often cover freestanding ambulatory surgical centers, as well as mental health clinics under this category.
Prescription drugs	Covered by private prescription drug plans. Inpatient drugs (i.e., drugs provided in nursing homes and hospitals) are covered under Medicare Part A.	Optional. Covered by all states and D.C. For dual eligibles, states may not cover drugs in those drug categories that are covered by Medicare Part D.
Dental	Not covered (with a few exceptions).	Optional. Covered by 43 states and D.C. Some states may limit services to emergency dental services; others may also provide preventive services.
Intermediate care facility for persons with mental retardation	Not covered.	Optional. Covered by all states and D.C. Generally, states do not limit the duration of coverage.

Type of Service	Coverage Under Medicare	Coverage under Medicaid (see note below)
Personal care	Not covered.	Optional. Covered by 35 states and D.C.
Private duty nursing	Not covered.	Optional. Covered by 26 states and D.C. States may limit the duration of services covered.
Home and community-based waiver services under Section 1915(c) of the Social Security Act	Not covered.	Optional. As of July 2003, there were 275 waivers operating in 49 states and D.C. These waivers provide a broad range of home and community-based long-term care services.
Home and Community-Based Services State Plan Option	Not covered.	Optional. Allows states to cover home and community-based long-term care services for beneficiaries with disabilities or chronic conditions, starting in January 2007. This benefit is limited to individuals whose income does not exceed 150% of the federal poverty level.

Source: CRS analysis of Medicare & You 2006 Handbook; Medicaid At-A-Glance, 2005; unpublished Medicaid waiver data, FY2003; and CRS Report RL30526, *Medicare Payment Policies*, by Sybil Tilson et al.; Deficit Reduction Act of 2005 (P.L. 109-171).

Note: This does not include required services for children under the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program under Medicaid. For additional state-specific information on covered services, see the Medicaid Benefits: Online Database, at [http://www.kff.org/medicaid/benefits/index.jsp?CFID=5623668&CFTOKEN=81000927].

Some federal and state policymakers have tried to address the challenges of the fragmentation in Medicare and Medicaid services by developing a coordinated and/or integrated approach to delivering both Medicare and Medicaid services through managed care. This report (1) explains the rationale for integrated managed care programs and describes the various approaches to integration; (2) reviews existing Medicare/Medicaid integration projects; (3) outlines common challenges faced in developing these projects; and (4) provides policy considerations for Congress.

Rationale for Integration Through Managed Care

As described above, the Medicare and Medicaid services that dual eligibles receive do not blend seamlessly with one another. The programs almost always have different eligibility requirements and scope of coverage for the same (or similar) services, as shown in **Table 1** above. In some cases, there are incentives for providers and payers to shift costs from one program to another (e.g., moving an individual from a Medicaid-funded nursing home to a Medicare-funded hospital stay when an individual could have remained in a nursing facility for treatment, or unnecessarily placing an individual enrolled in a Medicare managed care plan in a

Medicaid-funded nursing facility), which may save dollars for one program but generate higher total expenditures on an individual than without the cost-shifting.

Possible results of this fragmentation can include providers lacking information about the full range of services someone receives, which could compromise health care decision-making and health outcomes. Fragmentation can also lead to cost inefficiencies in Medicare and Medicaid, as well as beneficiary confusion about what is covered and by whom.

To improve coordination between Medicare and Medicaid, one approach has been to integrate these two programs through managed care. Under managed care, a single entity, a managed care organization (MCO), receives two fixed, predetermined monthly payments (i.e., the capitation rates). These payments include one made by CMS on behalf of the Medicare program and the other made by the Medicaid agency on behalf of the Medicaid program.

There are different types of integration plans. Some plans developed by federal and state policymakers cover the full range of Medicaid benefits; others have excluded certain Medicaid benefits from managed care (e.g., long-term stays in a nursing facility). The managed care plans may also establish various clinical care coordination efforts to further integrate services and address an individual's health care needs, such as developing an interdisciplinary care team. Examples of federal and state projects that integrate Medicaid and Medicare are provided later in this report.

The advantages cited by policymakers for integrating Medicare and Medicaid under a managed care program are provided below (readers should note that Medicare/Medicaid integration projects are not the only method of achieving these program improvements):

- reducing fragmentation and improving service coordination;
- removing the incentive to cost-shift from one program to another and increasing care accountability;
- enhancing the quality of care and improving health outcomes;
- increasing flexibility in the types of services that can be provided to beneficiaries;
- focusing on prevention and care coordination activities in delivering health care services;
- reducing hospitalization and nursing home use, with more emphasis placed on home and community-based supports; and
- creating budget predictability for state Medicaid agencies — particularly in preparation for demographic changes with the aging of the population.

Though supporters of integrated Medicare/Medicaid projects have cited many advantages, managed care is not without opposition. As discussed in more detail later in this report, providers may have concerns about the additional requirements or financial impact of operating under a managed care environment. Beneficiaries may be concerned that their ability to select a provider will be restricted (or they may have to change providers), that cost considerations by the managed care plan will

reduce the quality and availability of services, and that the contracted managed care plans and available providers may lack knowledge and experience with the needs of dual eligibles, many of whom have chronic health care conditions.

Types of Integration and Federal Authority

The integration of Medicare and Medicaid can occur through various contractual arrangements between the federal and state governments and the MCO.[6] In some cases, the state will initiate an integrated Medicare and Medicaid program, require that Medicaid managed care plans also become Medicare-approved plans, and develop a contractual relationship or agreement with CMS to coordinate both Medicare and Medicaid requirements (e.g., a memorandum of agreement between the state and CMS). In other cases, the managed care plan initiates an integrated Medicare and Medicaid program without a coordinated effort by CMS and the state to streamline the requirements of Medicaid and Medicare operations.[7] In cases where the managed care plan is initiating the integration project, the state and CMS must still be willing to contract with, and work with, the plan to successfully implement the project.

Most managed care programs in Medicaid and Medicare (including Medicare/Medicaid integration projects) require some form of federal approval under one of several possible authorities. Certain types of federal approval will occur more quickly than others. A brief discussion of each managed care authority is provided below, as well as the program options for managed care for dual eligibles.

Under Medicaid, managed care programs are available using the following program authorities:

- ***Pre-paid health plans***: These are generally used if a state wants to include only a few services in a managed care plan. Enrollment in the program must be voluntary.
- ***Section 1915(a) or Section 1932 of the Social Security Act***: These authorities include managed care options that are available under the Medicaid state plan; they do not require a waiver. Enrollment in managed care programs for dual eligibles must be voluntary under these authorities.
- ***Section 1915(b) waiver of the Social Security Act***: This waiver allows states to require that dually eligible individuals enroll in a managed care program to receive their services. The waiver must be cost-effective over a two-year period.
- ***Section 1115 waiver of the Social Security Act***: This waiver authority is very broad. In this context, it allows states to expand

[6] In this report, the discussion of managed care plans includes PACE programs because they operate under a capitated payment methodology.

[7] For a more detailed discussion of various integration approaches, see *State Guide to Integrated Medicare & Medicaid Models*, by CMS, released Mar. 2006, at [http://new.cms.hhs.gov/DualEligible/Downloads/StateGuide.pdf].

Medicaid eligibility, and require dually eligible individuals to enroll in managed care to receive services. The waiver must be budget neutral over five years.

- ***Program of All-Inclusive Care for the Elderly (PACE) program***: The Medicaid component is authorized under Section 1934 of the *Social Security Act* and is a Medicaid state plan option; it does not require a waiver. Enrollment in PACE programs must be voluntary. The PACE program, by definition a Medicare/Medicaid integration project, is described in more detail below.

Though not a specific managed care authority, Section 1915(c) of the Social Security Act has been combined with one of the authorities listed above to provide home and community-based long-term care services under a managed care environment. Several states (Minnesota and Texas, for example) have received approval for these types of combination waivers (e.g., Section 1915(a)/(c) or Section 1915(b)/(c) waivers).

Enrollment in Medicare managed care programs must be voluntary for all beneficiaries. Medicare managed care programs can be developed under the following program authorities:

- ***Medicare Advantage***: Medicare Advantage (MA) is the voluntary managed care option under Medicare law (Part C of Title XVIII of the Social Security Act). Managed care plans that apply to CMS to become an MA plan must provide all Medicare-covered items and services (including, in most cases, prescription drugs) for enrollees. Generally, MA plans have been unable to limit enrollment to only certain types of Medicare beneficiaries, such as dually eligible individuals, unless they are designated as Medicare Special Needs Plans, described below.[8]
- ***Medicare Special Needs Plan***: Medicare Special Needs Plans (SNPs) are a type of Medicare Advantage plan authorized under the *Medicare Modernization Act of 2003* (MMA, 108-173).[9] MMA permits SNP plans to limit enrollment to certain types of Medicare beneficiaries (e.g., dual eligibles). The SNP plan must cover all Medicare benefits for each enrollee. Enrollment in SNPs must be voluntary for beneficiaries. The SNP option is discussed in more detail below.
- ***PACE***: The Medicare component of PACE is authorized under Section 1894 of the *Social Security Act*. Enrollment in PACE programs must be voluntary. A more complete description of the PACE program is provided below.

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[8] For additional information, see CRS Report RS21761, *Medicare Advantage: What Does It Mean For Private Plans Currently Serving Medicare Beneficiaries?*, and CRS Report RL32618, *Medicare Advantage Payments*, both by Hinda Chaikind and Paulette C. Morgan.

[9] For additional information, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O'Sullivan et al.

- ***Section 222 waiver***: Under a Section 222 waiver, CMS can develop demonstration projects that evaluate changes in methods of Medicare payment or reimbursement.[10] In the past, CMS has applied this authority to certain Medicare/Medicaid integration projects for dual eligibles to allow the managed care plans to receive a Medicare capitated adjusted payment that accounts for the level of frailty of all community-dwelling enrollees aged 55 and over.

Background on Managed Care for Dual Eligibles

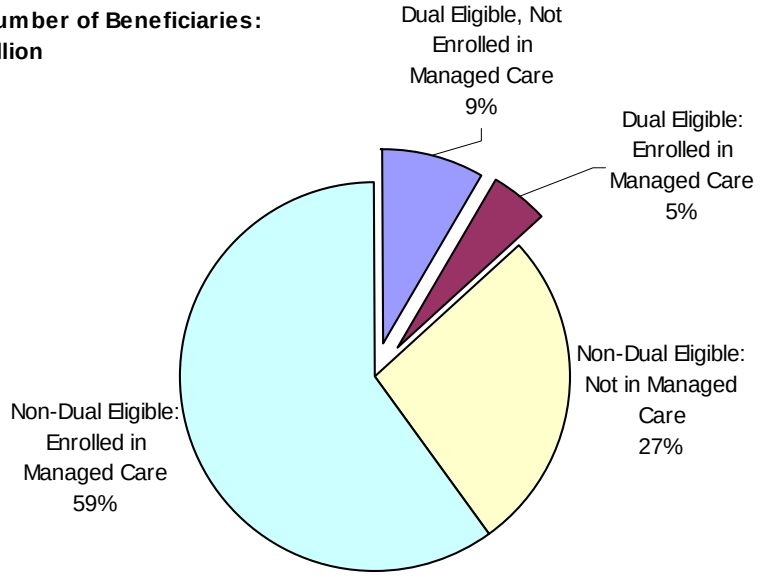
To provide context for the discussion of specific Medicare/Medicaid integration projects, this section describes managed care enrollment for dual eligibles generally under Medicaid and Medicare. Under Medicaid, managed care has become a fairly widely accepted service delivery system for many Medicaid beneficiaries. In June 2004, only three states (Alaska, New Hampshire, and Wyoming) did not enroll beneficiaries in some form of Medicaid managed care. In June 2004, 61% of Medicaid beneficiaries were enrolled in some form of managed care. Many states (23 in June 2004), however, continue to exclude dual eligibles from managed care enrollment.[11] Nationwide, about 35% of dual eligibles in FY2003 (the most recent data available) were enrolled in some form of Medicaid managed care program.[12] See **Figure 1**.

[10] Refers to Section 222 of the *Social Security Amendments of 1972*.

[11] CRS analysis of CMS, Medicaid managed care enrollment data, June 2004.

[12] CRS analysis of Medicaid Statistical Information System (MSIS) data, FY2003.

Figure 1. Medicaid Managed Care Enrollment of Beneficiaries by Dual Eligible Status, FY2003



Source: CRS analysis of CMS, Medicaid Statistical Information System (MSIS), FY2003.

Generally, states have limited the covered benefits under Medicaid managed care to acute and primary care services (e.g., physicians, hospital). A few states, however, also deliver long-term care services through managed care; in 2004, an estimated 2.3% of individuals receiving long-term care were receiving these services through managed care (including both dual eligibles and non-dual eligibles).[13] Because nearly 70% of Medicaid expenditures for dual eligibles is spent on long-term care services, states developing integrated Medicare/Medicaid programs have a significant financial incentive to include long-term care services in the scope of covered benefits under managed care where their exposure to expenditures is limited to a monthly capitation payment. However, as discussed in more detail later in this report, most managed health care companies have limited experience in managing long-term care services.

Under Medicare, though managed care options have been available under the program since the early 1980s, the percentage of Medicare beneficiaries enrolled has been much lower than that of Medicaid since enrollment in managed care must be voluntary. To encourage enrollment, some managed care plans offer beneficiaries supplemental benefits (e.g., eyeglasses, dental). Despite the availability of supplemental benefits, in September 2006 (the most recent data available), only 17%

[13] P. Saucier et al., *The Past, Present and Future of Managed Long Term Care*, MEDSTAT and the Muskie School of Public Service, submitted to the Department of Health and Human Services, Apr. 2005. (Hereafter cited as "P. Saucier et al., Managed Long Term Care.")

of Medicare beneficiaries were enrolled in Medicare managed care.[14] In April 2006, less than 2% of dual eligibles were enrolled in managed care for their Medicare services.[15] This does not include the Part D prescription drug benefit, in which all dual eligibles are enrolled in a private stand-alone prescription drug plan (PDP) or a prescription drug plan associated with a Medicare Advantage plan (MA-PDP).

Selecting Managed Care Plans and Setting Payment Rates Under Medicaid and Medicare

As described earlier, in Medicare/Medicaid integration projects, a managed care plan becomes *both* a Medicaid managed care plan and a Medicare managed care plan. The MCO receives two fixed, predetermined monthly payments (i.e., the capitation rates) from the state Medicaid agency and CMS to provide the Medicaid and Medicare services a beneficiary needs. Although the plan may operate as an integrated plan, the managed care plan must follow separate requirements for Medicaid and Medicare to become an approved managed care plan. Plans are also paid through separate Medicare and Medicaid payment mechanisms, which use different methodologies to set capitation payments for an individual. Additional details about the bidding and rate-setting process for Medicaid and Medicare are described below.

For Medicaid, the process to select a managed care plan and the methodology to set the capitation payment rate vary widely by state. Most states issue a request for proposal (RFP) that outlines the features of the proposed managed care program (e.g., covered beneficiaries and services, required grievance and appeal processes, required provider networks). Interested managed care plans submit proposals to the state in response to the RFP. From those responses, the state selects the managed care organization(s) and awards it a Medicaid managed care contract to provide the Medicaid services specified in the RFP. Often states enter into multi-year contracts with these organizations. Some states allow for a public comment period while developing an RFP; others do not.

The process for establishing the capitation rates for Medicaid also varies widely by state. Federal law and regulation require that the capitation payments meet an "actuarial soundness" requirement and are approved by CMS. So long as the capitation payment meets these two requirements, the state has a significant amount of flexibility in how it establishes and negotiates the payment rates for a specific year. For example, states may use different data sources to establish baseline medical costs, or different factors to account for medical inflation among providers. Some states adjust the payment rates to account for disability or institutional status or pregnancy; others only consider demographic factors such as age and gender. Some states have a "collaborative" process between the state and the managed care plan to

[14] S. Peterson and M. Gold, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for September 2006*, Mathematica Policy Research, Inc., Oct. 6, 2006.

[15] Unpublished data from the Centers for Medicare and Medicaid Services, Apr. 2006.

establish the payment rates; in other states, plans are less involved in the rate development process.[16]

Under Medicare, beginning in 2006, Medicare Advantage (MA) plans are selected through a federally administered bidding process. An organization applying to become an MA plan submits an annual application to CMS that meets certain requirements and a bid of the expected costs for providing services in a specific geographic area. The bid includes the costs of providing Medicare Part A and B benefits, Part D prescription drugs (if applicable), and supplemental benefits, if any (including reductions in cost sharing).

CMS's payment to an MA organization for an MA plan's coverage of Medicare Part A and B (A/B) benefits depends on the relationship of the plan's bid to an established benchmark for that geographic area. For MA plans with a basic A/B bid below the benchmark, CMS will pay the MA organization the basic A/B bid amount, adjusted by the individual enrollee's risk factor, plus the rebate amount. The individual enrollee's risk factor is determined using a CMS-developed model that accounts for individual differences in health status, known as the Hierarchical Condition Category (CMS-HCC) model. The rebate part of the payment is 75% of the difference between the plan bid and benchmark, and is used to provide mandatory supplemental benefits or reductions in Part B or Part D premiums. CMS retains the other 25%. For a plan with a bid equal to or above its benchmark, CMS pays the MA organization the plan benchmark, adjusted by the individual enrollee's risk factor using the CMS-HCC model. In addition, CMS pays the bid amount, if any, for Part D basic coverage.[17]

Medicare Special Needs Plans and Passive Enrollment

As discussed above, the *Medicare Modernization Act of 2003* (MMA) created a new type of Medicare Advantage (MA) plan known as the "special needs plan" (SNP). SNPs must follow all of the MA program rules, but are permitted to limit enrollment to certain categories of Medicare beneficiaries, including (1) dual eligibles, (2) individuals with severe and disabling chronic health care conditions, and (3) those who are institutionalized. Previously, Medicare managed care plans had to enroll all Medicare beneficiaries and could not limit enrollment to a certain population. Though plans are not required to integrate with state Medicaid programs, the SNP option was intended to improve care coordination for individuals with complex health care needs — one approach to increased care coordination would be the development of Medicare/Medicaid integration projects, which the SNP option facilitates.

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[16] G. Catterrall, et al., *Rate Setting and Actuarial Soundness in Medicaid Managed Care*, A Report for the Association for Community Affiliated Plans and The Medical Health Plans of America, Jan. 23, 2006, at [http://www.mhpa.org//pdf/misc/ACAP_MHPOAreport.pdf].

[17] For additional information, see CRS Report RL32618, *Medicare Advantage Payments*, by Hinda Chaikind and Paulette C. Morgan.

In the fall of 2005, CMS permitted a subset of SNPs (42 plans in 13 states) to passively enroll dual eligible individuals into the plan's Medicare SNP program if the individual was already enrolled in the plan's Medicaid managed care plan. The passive enrollment process was a one-time event that was part of the implementation of the new Medicare drug benefit. Dual eligibles were moved from the Medicare fee-for-service system into a Medicare SNP starting on January 1, 2006. Individuals could opt out of passive enrollment and switch to another prescription drug plan, and back to the Medicare fee-for-service system for other Medicare services. The passive enrollment process significantly increased the level of beneficiary participation in a single plan with both a Medicare and Medicaid contract. Some of these plans are making a concerted effort to integrate Medicare and Medicaid services.[18]

The SNP market is in the early stages of development. In 2006, 276 SNPs participated (with plans available in some areas of 41 states and Puerto Rico). Most of the SNP plans in 2006 focused on dual eligibles.[19] However, it is unclear how many of the SNP plans are contracting with both CMS and a state Medicaid agency (or intend to do so in the future), and to what extent the Medicare and Medicaid services are delivered in an integrated manner.

Summary of Medicare/Medicaid Integration Projects

Several federal and state programs currently offer integrated Medicare and Medicaid services.[20] Each of these programs is described in more detail below.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) covers an integrated set of Medicare and Medicaid services, including both acute and long-term care for program participants. PACE was initially authorized by Congress as a demonstration in 1986; however, the Balanced Budget Act of 1997 (BBA97, P.L. 105-33) established PACE as a permanent option under both Medicaid and Medicare. Unlike other state integration programs, the PACE program operates under a coordinated set

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[18] The Pennsylvania Health Law Project filed a class action lawsuit against CMS for allowing plans to passively enroll beneficiaries into Medicare managed care. Under the lawsuit's settlement agreement, passive enrollment is not permitted in Pennsylvania, but can still occur in other states. Inside CMS, *CMS to Stop Allowing Passive Enrollment of Duals Under PA Settlement*, Apr. 6, 2006.

[19] C. Peters, *Medicare Advantage SNPs: A New Opportunity for Integrated Care*, National Health Policy Forum, Issue Brief No. 808, Nov. 2005.

[20] In the past, there were three other federal demonstrations that capitated Medicare payments under managed care, but these programs were generally not integrated with *Medicaid* managed care. These demonstrations included the two Social Health Maintenance Organization (S/HMO-I and S/HMO-II) demonstrations and EverCare. All of these demonstrations have become Medicare special needs plans (SNPs), and are no longer demonstrations. For additional information, see [http://www.cms.hhs.gov/DemoProjects EvalRpts/downloads/SHMO_Summary.pdf] and [http://www.cms.hhs.gov/DemoProjects EvalRpts/downloads/Evercare_Summary.pdf].

of federal rules and requirements outlined in Medicare and Medicaid law and regulation.

Individuals qualify for PACE if they reside in a PACE service area, are aged 55 or older, and meet a nursing facility level of care. The PACE program is modeled after the On Lok demonstration in San Francisco, California.[21] The PACE staff includes an interdisciplinary team of staff physicians, nurses, social workers, case managers, and other professionals. PACE services are generally delivered at a specific site that is also an adult day center, but may also be supplemented by in-home services or referrals.[22]

The Medicare capitation payment methodology for PACE differs from the methodology used for other Medicare Advantage organizations, discussed earlier in this report. The Medicare capitation payment for PACE is based on a combination of two formulas: (1) a county rate multiplied by a uniform demographic PACE frailty adjuster (to account for functional limitations such as eating or walking), and (2) a risk-adjusted payment methodology used by the general Medicare Advantage program.[23] The Medicare capitation payment for PACE (along with three state integration projects, discussed later in this report) is in the process of transitioning to the methodology of the overall Medicare Advantage program based on a 100% risk adjustment. CMS is still determining whether an additional frailty factor will be applied to all Medicare Advantage plans in the future. Under the Medicaid program, the monthly capitation rate is negotiated between the PACE provider and the state Medicaid agency, and is specified in the contract between them.[24]

Because PACE enrollees regularly attend adult day centers where PACE services are provided, and because of the interdisciplinary staffing model, most PACE sites are generally implemented in urban areas, and enrollment is limited to a few hundred individuals at each site. As of November 2005, there were 34 PACE sites nationwide enrolling about 11,200 individuals.[25] To promote the development of additional PACE sites in rural areas, the *Deficit Reduction Act of 2005* (P.L. 109-171) established a grant program for up to 15 pilot PACE providers in rural areas.

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[21] For a full history of PACE, see [http://www.npaonline.org/website/article.asp?id=12].

[22] An adult day center refers to services and assistance provided to multiple individuals with a disability or chronic condition in a group setting which generally operates during daytime hours.

[23] [http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf].

[24] [http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf].

[25] The National PACE Association website provides information on each of the PACE sites, for additional details, see [http://www.npaonline.org/website/article.asp?id=71].

State Integration Programs

Several states have also developed Medicare/Medicaid integration projects for dual eligibles.[26] These programs vary in design and in the scope of services covered. Some states, such as Arizona and Texas, have mandatory Medicaid managed care programs that enroll both dual eligible and non-dual beneficiaries. Some of the participating managed care plans may also offer a companion Medicare managed care plan for dual eligibles. The managed care plan is responsible for integrating the services for dual eligibles at the plan level. Even though the plan may be responsible for integrating services, the state must be willing to contract with the plan for the Medicaid services, and may have requirements in the Medicaid contract that a plan become certified as a Medicare Advantage plan.

Other states such as Wisconsin, Minnesota, and Massachusetts have developed voluntary Medicare/Medicaid integration projects, and have actively worked with CMS to streamline Medicare and Medicaid requirements for participating plans by developing formal agreements between the state and CMS. In these projects, the state requires that participating plans are approved as both Medicaid and Medicare managed care plans. These and other operational state integration projects are discussed in more detail below.

Arizona Health Care Cost-Containment System (AHCCCS). Arizona operates a statewide mandatory managed care program for most Medicaid beneficiaries referred to as the Arizona Health Care Cost-Containment System (AHCCCS). Arizona also has a separate component of AHCCCS for those who qualify for long-term care services, known as the Arizona Long-Term Care System, (ALTCS). Collectively, these programs cover most Medicaid services through managed care.[27]

In the fall of 2005, CMS allowed six Medicare Advantage SNP (MA SNP) plans in Arizona to passively enroll any dual eligible in Medicare managed care if the individual was enrolled in that same organization under a Medicaid managed care plan. Dual eligibles who do not opt out of passive enrollment will be enrolled in the same managed care plan for both their Medicare and Medicaid services. Several of these plans are *actively* integrating both Medicare and Medicaid services for these individuals.

In spring 2006, Arizona issued a solicitation to re-compete the managed care contracts with plans to implement and operate ALTCS. As part of that solicitation, Arizona required that managed care plans either become an MA SNP, or have a formal relationship with an MA or MA SNP organization to improve care coordination for dual eligibles.[28] In May 2006, Arizona awarded contracts to eight managed care plans under this solicitation to provide ALTCS services.

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[26] Some of these projects also enroll non-dual, Medicaid-only beneficiaries.

[27] See [http://www.ahcccs.state.az.us/publications/overview/2004/contents.asp].

[28] See [http://www.azahcccs.gov/Contracting/BiddersLibrary/ALTCS/Conference/ALTCS_RFP_OfferorsPresentation.ppt].

Massachusetts Senior Care Options. In 2004, Massachusetts implemented an integrated Medicaid/Medicare program known as "Senior Care Options." Medicaid beneficiaries aged 65 and older in most areas of the state can *voluntarily* enroll in a managed care plan for all of their Medicare and Medicaid services. The Senior Care Options program requires that managed care plans also be MA plans, and that individuals enroll in the same managed care company for their Medicare and Medicaid services.

As part of Massachusetts's program, CMS (under Section 222 demonstration authority) permitted the Medicare capitation payment to be calculated using the PACE program methodology — applying a frailty adjuster to account for the increased level of impairment among enrollees.[29] Similar to PACE, the Massachusetts project is transitioning from a payment methodology that includes both a frailty adjuster and risk-adjustment, to the standard Medicare Advantage payment methodology, which does not include a frailty adjuster.

Minnesota Senior Health Options (MSHO) and Disability Health Options (MnDHO). For nearly 10 years, Minnesota has operated voluntary integrated Medicare and Medicaid projects, one initiative for the elderly (MSHO), starting in 1997, and another for adults with disabilities (MnDHO), starting in 2001. The Minnesota integration projects cover all Medicare services and most Medicaid acute and long-term care services. Similar to Massachusetts, the Medicare capitation payment uses the PACE payment methodology, described earlier, under the authority of a Section 222 demonstration. The additional frailty adjuster will also be phased out, effective December 31, 2007.

In 2005, MSHO expanded to become a statewide option for beneficiaries. Though MSHO is voluntary, individuals who do not choose MSHO are required to enroll in another Medicaid managed care program. For adults with severe disabilities under age 65, MnDHO is a voluntary alternative to the Medicaid fee-for-service system, and is available in seven counties.

In 2006, all participating MSHO and MnDHO plans became Medicare SNPs. Under an agreement between the state and CMS, these Medicare managed care plans are permitted to continue operating separate programs for the elderly and adults with disabilities through December 2007.[30]

Following the Medicare passive enrollment process for dual eligibles (described earlier in this report), MSHO enrollment jumped from 9,800 in November 2005, to 33,400 in January 2006. MnDHO currently enrolls about 600 individuals.[31]

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[29] See [http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/DESM_Mass_Fact_Sheet.pdf].

[30] Other SNPs must enroll all individuals in the group covered (e.g., dual eligibles), regardless of age.

[31] P. Parker, *Special Needs Plans & Medicaid: The Minnesota Experience, Presentation at the Medicare Advantage Congress,* Jan. 26, 2006.

New York Medicaid Advantage Program. In January 2005, New York offered dual eligibles aged 21 and older the option of voluntarily enrolling in an integrated Medicare and Medicaid program. This plan provides all Medicare services and *certain* Medicaid services, including most acute care services not covered by Medicare and a limited set of long-term care services.[32] Participating plans must be both Medicare Advantage and Medicaid managed care plans. The Medicaid Advantage program is available statewide, and in March 2006, enrolled about 3,800 dual eligibles.[33]

Texas Star+Plus. Texas STAR+PLUS is a mandatory Medicaid managed care program that integrates delivery of all Medicaid acute and long-term care services and for some participants, also integrates Medicare services. The program covers most Medicaid recipients who are elderly or have disabilities in Harris County (which includes Houston). As of June 2004, Texas Star+Plus enrolled about 52,900 individuals, including both dual eligibles and non-dual eligibles.

Dual eligibles have the choice between two Medicaid managed care plans; both of the plans are also certified as Medicare SNPs and receive a Medicare capitation rate to cover all Medicare services.[34] Enrollment in the Medicare managed care portion is voluntary. To encourage beneficiary participation, the plans and the state highlight the additional prevention and care coordination activities that are available if a dual eligible enrolls in the companion Medicare plan for his or her Medicare services. In fall 2005, 20,000 dual eligibles who were participating in Texas Star+Plus were passively enrolled into their companion Medicare managed care plan.[35]

Texas STAR+Plus was slated for expansion to all the state's urban areas, but ultimately was not approved by the state legislature because the expansion efforts would have made urban hospitals ineligible for approximately $75 million per year in funds generated through the federal upper payment limit (UPL) mechanism.[36] The UPL mechanism allows states to make supplemental payments (up to the Medicare rate) for care provided at government facilities, allowing these states to claim additional federal matching dollars. A provision in the state's recent biennial budget directed the Texas Health and Human Services Commission to develop an

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[32] See [http://www.health.state.ny.us/health_care/managed_care/partner/operatio/prot29.htm].

[33] See [http://www.nyhealth.gov/health_care/managed_care/reports/enrollment/monthly/2006/docs/en3_06.pdf].

[34] For additional information, see [http://www.hhsc.state.tx.us/starplus/starplus.htm].

[35] P. Saucier, *Managed Care for Special Populations: State and Federal Developments*, Presentation at PACE Spring Policy Forum, May 1, 2006.

[36] For additional information, see CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia J. Herz.

appropriate care management model to be used in other areas of the state, as long as it would preserve UPL to hospitals.[37]

On April 26, 2006, the Texas Health and Human Services Commission announced that Texas Star+Plus would be expanding to include three other service areas of the state, with five managed care plans tentatively scheduled to provide services starting in January 2007. The payment structure for inpatient hospitals within Texas Star+Plus would preserve UPL funding to hospitals.[38]

Washington Medicare/Medicaid Integration Program. Effective June 1, 2005, dual eligibles aged 65 years and older who live in King and Pierce counties could voluntarily enroll in an integrated Medicare/Medicaid program with Evercare Premier.™ CMS initiated the project and selected Evercare Premier through a formal solicitation process to offer Medicare managed care as a Medicare SNP. CMS pays Evercare Premier the capitation rate for Medicare services, and the state pays the Medicaid capitation payment for those Medicaid services not covered by Medicare, including long-term care services. The state expects 600 to 1,000 individuals to enroll in this project.[39]

Wisconsin Partnership Program. Wisconsin operates a voluntary integrated Medicare and Medicaid project that covers most acute and long-term care Medicaid services and all Medicare services. The Wisconsin Partnership Program (WPP) has four sites serving a total of six counties that provide services to older adults and individuals with disabilities who require the level of care needed in a nursing facility. The Medicare capitation payment also uses the PACE payment methodology under Section 222 demonstration authority. Similar to the projects in Massachusetts and Minnesota, WPP is transitioning to the Medicare Advantage payment methodology in the future. As of February 2006, WPP enrolled about 1,900 individuals. Wisconsin has been pursuing efforts to expand its managed care initiatives for the elderly and those with disabilities, which could include an expansion of WPP.[40]

Other Activities

Several other states (California, Florida, and Maryland) are in the formative stages of developing integrated Medicare/Medicaid programs. The **Appendix** at the end of this report has a more detailed description of activities in these states.

There is no comprehensive list of the numbers of managed care plans that may be integrating Medicare and Medicaid services at the plan level. From the state or

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[37] See Texas State Legislature, *Seventy-Ninth Legislature, Text of Conference Committee Report, Senate Bill No. 1 Regular Session*, p. II-110, at [http://www.lbb.state.tx.us/Bill_79/8_FSU/79-8_FSU_0905.pdf].

[38] See [http://www.hhsc.state.tx.us/medicaid/Contract_Amendment.html].

[39] For additional information, see [http://fortress.wa.gov/dshs/maa/mmip/].

[40] For additional information, see [http://www.dhfs.state.wi.us/WIpartnership/] and [http://dhfs.wisconsin.gov/LTCare/rfi/RFI10-20-05.pdf].

CMS perspective, these plans may not be distinguishable from nonintegrated plans. For example, several large Medicaid managed care organizations have become Medicare SNPs in Hawaii, Oregon, Arizona, and Rhode Island.[41] It is unclear what level of integration this will bring; some plans may be covering both Medicare and Medicaid services but not integrating those services through a coordinated delivery system. For example, the Medicaid and Medicare services may be delivered by different organizational units of the plan.

The scope of services may also differ. Plans in the states discussed earlier are providing and integrating both acute and some long-term care services; however, plans in other states may be solely focused on integrating acute care services (with long-term care services still provided through the Medicaid fee-for-service system.)

Finally, a private nonprofit organization, the Center for Health Care Strategies, Inc. awarded funding to five states (Florida, Minnesota, New Mexico, New York, and Washington) to integrate the financing, delivery, and administration of primary, acute, long-term care, and behavioral health services. The initiative is focused on beneficiaries who are elderly and those with disabilities who are either enrolled in Medicaid or are dual eligible. Some of these states have existing projects that they are expanding; others are in the initial stages of development.

Results of Integration Projects

The studies evaluating integrated Medicare and Medicaid programs have been somewhat limited in the length of the evaluation period but have generally evaluated a broad range of topics (e.g., cost, utilization, consumer satisfaction). This report focuses on the available outcomes related to service utilization, cost, and mortality.

Generally, evaluations of Medicare/Medicaid integration projects have shown decreased utilization of high-cost services such as emergency room, hospital, and nursing facility services, and increased access to home and community-based long-term care services. Evaluations of the fiscal impact of these programs have been inconclusive. In some cases, expenditures were higher than a fee-for-service comparison group; in other cases, the net cost was comparable — there were savings to Medicare that were offset by higher Medicaid expenditures.[42]

In the area of mortality, results were mixed. In evaluations of PACE and the WPP program, the mortality rates for PACE enrollees and younger adults with disabilities in WPP were lower than for comparison groups.[43,44] An evaluation of Minnesota's MSHO program found no differences in mortality rates for MSHO

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[41] J. Packer-Tursman, "Regence Balks at Offering Regional Plan, But MA Plans Target '07 MA Entry," *Medicare Advantage News*, Jan. 26, 2006.

[42] P. Saucier et al., *Managed Long Term Care*.

[43] See [http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PACE_Summary.pdf].

[44] R. Kane and P. Hornyak, *Multi State Evaluation of Dual Eligibles Demonstration*, Aug. 2004.

enrollees compared to a control group. Other quality indicators were similar for MSHO enrollees and a comparison group. The evaluation did, however, find significant differences in the reported burden of family caregivers, with the families of MSHO enrollees having more positive outcomes.[45]

Challenges in Developing Medicare/Medicaid Integration Projects

This section discusses common challenges in developing integrated Medicare and Medicaid programs (though specific circumstances will vary by state and by program.)[46] The description of challenges is not intended to presuppose that managed care is preferable to the traditional fee-for-service approach. While reducing fragmentation of services and increasing care coordination seem to be worthy policy goals, other factors (e.g., freedom of choice in one's provider) must also be evaluated.[47]

Level of State Investment and Expected Returns on Investment

Though states may see a benefit from the greater budget predictability and accountability through managed care, the available studies indicate that cost savings for dual eligibles will likely be realized by Medicare and/or the managed care plan because of the lower utilization of primarily *Medicare-funded services* (e.g., emergency room, inpatient hospital, and short-term nursing facility stays) and the increased utilization of *Medicaid-funded,* home and community-based, long term care services (e.g., personal care, and Medicaid home and community-based waiver services).[48] Depending upon the structure of the program, states may see *some* Medicaid savings if there are reductions in long-term nursing facility stays under these integrated programs, or if the Medicare capitation payment results in coverage of supplemental services that otherwise would have been covered by Medicaid.

In addition to issues related to the impact of these programs on the Medicaid budget, developing Medicare/Medicaid integration projects takes a substantial investment in state time and resources. For the existing state projects that required federal waiver(s) for Medicaid under Section 1115 or Medicare under Section 222,

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[45] R. Kane, et al., "Outcomes of Managed Care of Dually Eligible Older Persons," *The Gerontologist*. Apr. 2003.

[46] Information gathered through interviews with selected state staff, CMS, and other researchers.

[47] For an overview of general operational concerns about managed care, see R. Kronick, "Waiting for Godot: Wishes and Worries in Managed Care," *Journal of Health Politics, Policy and Law*, vol. 24, no. 5, Oct. 1999, pp. 1099-1106.

[48] States that also include elderly and those with disabilities who are not dual eligibles may realize savings from lower utilization in Medicaid-funded, high-cost, high-intensity services (e.g., hospital).

the federal approval process took several years. With the availability of the Medicare SNP option, federal approval for the Medicare managed care program may happen significantly faster than in the past. For Medicaid, in states that are interested in pursuing integration projects in which Medicaid enrollment would be *mandatory* or would have other features that require a federal waiver, the investment of time and resources may still be considerable. For integration projects with *voluntary* enrollment, federal approval may happen more quickly because of the various Medicaid managed care options under the state plan.

Beyond the time it takes to receive federal approval for integrated programs, a state may also need to become familiar with the Medicare managed care rules and regulations, and may have to determine how to structure the delivery of long-term care services in a managed care environment (e.g., service requirements, quality assurance mechanisms, availability of qualified plans, rate setting, and compatibility with a state's existing home and community-based waiver programs under Section 1915(c) of the *Social Security Act*). Though many states are familiar with the delivery of acute care services via managed care, fewer states have experience with managed long-term care services — which has a different infrastructure, set of providers, and constituencies than the acute care system.

Conflicting Medicare and Medicaid Requirements

Other significant challenges include the conflicting requirements between Medicare and Medicaid law, and the differing requirements for program administration, such as enrollment and disenrollment policies, beneficiary marketing, grievance and appeal processes, payment schedules, quality requirements, oversight, and data collection. These conflicts in some cases pose barriers to operating integrated Medicare/Medicaid programs.

Recently, CMS, states, and other technical assistance providers have been working to address these conflicts by identifying specific areas of conflict and posing administrative solutions. Some areas can be addressed by CMS through its administrative or regulatory authority, and other areas may require legislation to resolve the issues. For example, integrated Medicare/Medicaid managed care plans are subject to separate auditing requirements under Medicare (as conducted by CMS or CMS contractors) and Medicaid (as conducted by the state Medicaid agency and/or the state health department). CMS and the state could consider streamlining or coordinating the audits to make the process more efficient. Once these issues are addressed, a second step will be to ensure that there is consistent application across CMS Regional Offices, since some of the decision-making authority for these types of programs resides in each Regional Office.

Some of these issues have been addressed in administrative guidance issued by CMS. In July 2006, CMS released several "How To" guides for states and managed care plans that are implementing Medicare/Medicaid integration projects. The guides address the areas of enrollment, marketing, and quality, and are intended to clarify

Medicare and Medicaid rules and suggest processes that states and the plans can use to fulfill Medicare and Medicaid requirements.[49]

The issue of conflicting requirements does not apply to PACE demonstrations. The PACE sites follow a separate administrative review process and have separate statutory and regulatory guidance.

Managed Care Payment Rates

The rate-setting process for integrated Medicare and Medicaid projects may be difficult for some states to develop. The state may not know the details of the Medicare contract (e.g., what the plan submitted as a bid and what supplemental benefits the plan might offer). States may have difficulty determining how the plan's Medicare managed care bid fits with what the state would be paying the plan for its Medicaid services. This is complicated by the fact that the current Medicare Advantage payment methodology is changing. Starting in 2004, MA payments began including a risk-adjustment factor (calculated by the CMS Hierarchical Condition Category, or HCC, model). The CMS-HCC model continues to be updated and refined.[50]

Another challenge is that while many states are familiar with setting managed care rates for acute care services, they may not have experience in rate-setting that includes long-term care services — which has a different utilization pattern and a different set of providers. Some questions may include the following: How should the state account for individual differences in health status through risk adjustment for the elderly and those with disabilities? How can available data sources be used to inform the rate-setting process for long-term care?[51] In addition, states may want to build certain policy incentives into the rates — for example, to serve individuals in the community instead of in an institution. Addressing these issues may pose a challenge for some states.

Federal Waiver Approval

If the state's proposed program requires a waiver of Medicaid law (primarily for those programs with mandatory enrollment), one of the challenges states face is how a proposed Medicare/Medicaid integration project can meet any budget-neutrality or cost-effectiveness requirements associated with a waiver. Generally, budget-neutrality or cost-effectiveness requirements do not consider savings to Medicare as offsetting any increases in Medicaid expenditures; the fiscal impacts of the program

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[49] See [http://www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp].

[50] See [http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf].

[51] Personal Communication with Melanie Bella and Lindsay Palmer, Center for Health Care Strategies, Apr. 20, 2006. (Hereafter cited as Pers. Communication, M. Bella and L. Palmer)

to Medicaid and Medicare are evaluated separately. As described earlier, it is not clear that Medicaid costs decrease under Medicare/Medicaid integration projects.

Willingness of Medicare Advantage Plan to Contract with the State Medicaid Agency

Some Medicare Advantage plans (including SNPs) may not be interested in participating in a risk-based contract for Medicaid services (such as long-term care). These plans may focus efforts on solely delivering Medicare services and rely on Medicaid fee-for-service to provide wraparound benefits. The specific reasons will vary, but some of the concerns in contracting with the state could include

- limited experience with covering long-term care, which has different financial risks, providers, service requirements, and beneficiary concerns than acute care services;
- limited familiarity or experience with Medicaid contracting rules or a state's administrative processes;
- the potential for, or frequency of, changes to the state's Medicaid program (rates, benefit package);
- the expected level of enrollment, which may not be sufficient to take on the financial risk of participation, particularly if the program has voluntary enrollment; and
- the level of Medicaid managed care rates or the rate-setting methodology.

Ability of Medicaid Long-Term Care Providers to Meet Managed Care Requirements, and Cover Acute and Primary Services

Public or private organizations with experience in providing long-term care services may be interested in becoming a managed care plan under an integrated Medicare/Medicaid program. However, these providers may have limited experience with operating a managed care plan or covering acute and primary services. Developing knowledge and expertise in these areas may take a significant investment of time and resources. Some of these areas include (1) managing financial risk for various types of services (i.e., primary, acute, and long-term care); (2) developing and administering operation and information systems that gather, analyze, and report how participants are using covered services; and (3) establishing a process to allocate resources under managed care.

For those groups that have experience with Medicaid managed care, there may be other areas of knowledge and investment needed to become a qualified Medicare Advantage plan. For example, the organization may have to become familiar with the Medicare bidding process and meet other Medicare requirements, such as having

a certain amount of available capital in the organization and meeting minimum enrollment thresholds.[52]

Provider Issues

Upper Payment Limit Policies and Managed Care. Under the Medicaid program, states have broad flexibility in determining the payment rates for Medicaid providers; however, the total payments to hospitals and nursing facilities cannot exceed an upper payment limit (UPL), which is the rate that Medicare would have paid. Federal regulations outline the methodology states must use to report expenditures to ensure that Medicaid expenditures do not exceed the UPL limits. Some states have also used these UPL provisions to draw down additional federal Medicaid funding.[53]

Under current federal guidelines, states are not permitted to collect this additional funding by applying the UPL to Medicaid managed care rates. Under a managed care program, states and/or providers would be required to forego the additional federal Medicaid dollars generated through UPL funding arrangements. This loss of federal funding could provide a significant disincentive to states and providers to develop or participate in managed care programs.[54]

Alternatively, lower inpatient hospital and emergency room utilization have been sources of savings for Medicare/Medicaid integration projects — though these savings largely accrue to Medicare for dual eligibles.[55] In considering these integration projects, a state will have to consider the following: How much, if any, additional federal UPL funding would be lost by implementing a Medicare/Medicaid integration project? What, if any, impact would there be on public hospitals? What would be the expected cost or savings to the state budget?

In Texas, which was considering a statewide expansion of its integrated managed care program, the loss of federal revenue generated through UPL payments would have decreased funding to hospitals by approximately $75 million per year,

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[52] Pers. Communication, M. Bella and L. Palmer.

[53] For additional information, see CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia J. Herz.

[54] This issue is not unique to integrated Medicare/Medicaid projects; these requirements also apply to other Medicaid managed care programs. Some states implementing managed care have received waivers from CMS under Section 1115 of the *Social Security Act*, which has allowed them to preserve UPL funding.

[55] If the Medicaid managed care program also includes non-dual eligibles, savings would accrue to Medicaid since the services 'normally' covered by Medicare for dual eligibles (e.g., hospital stays) would be covered by Medicaid.

and was a significant enough barrier to block the proposed expansion of its integrated managed care program.[56,57]

Other Provider Concerns. In other cases, providers have been resistant to developing integrated Medicare/Medicaid managed care programs. There are concerns that the programs would change the patient-provider relationship, increase the provider's administrative burden, move the payment authority from the state agency or legislature to a managed care plan,[58] or impose more requirements for payment than existed under the fee-for-service system.

Some of these concerns were expressed by the Texas Medical Association (TMA) in the recent proposed expansion of Texas Star+Plus, excerpted below:

> While physicians support elements of STAR+PLUS, such as better integration and management of the continuum of care for eligible patients, TMA and local medical societies do not believe that another Medicaid managed care model can be integrated into the system without causing it to collapse. In areas with Medicaid managed care already, physicians and health care providers are already at their breaking points. The expansion of STAR+PLUS or other Medicaid managed care pilots will exacerbate existing Medicaid provider shortages.
>
> For example, if expanded, physicians in Dallas would have to contend with STAR, the physical health Medicaid managed care program; NorthSTAR, the Medicaid behavioral health pilot; CHIP; and STAR+PLUS. Each of the programs has different administrative and claims payment requirements, adding complexity to a system few physicians are willing to navigate today.[59]

Providers also have concerns that the programs would affect their current funding or service delivery system. For example, in 2005, California's state budget proposed piloting an integrated Medicare/Medicaid program in three counties. One of the concerns raised about the proposal was that the new program would disrupt the existing county-based in-home supportive services program (IHSS).[60] This concern was a significant factor in changing the proposal released in the 2006 budget, which now proposes to integrate all Medicare and Medicaid services except county-based IHSS services.

In some states, groups representing the nursing home industry have also expressed concerns about managed care programs that include long-term care services. These types of programs have generally been shown to decrease nursing home utilization and increase the availability and provision of home and community-based services. Groups representing the nursing home industry may express concerns if, in their view, such programs would divert money that would otherwise be spent

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[56] [http://www.hhsc.state.tx.us/pubs/022305_FIPPMCE.html].

[57] [http://www.hhsc.state.tx.us/news/meetings/past/2005/Council/HealthServices_062405.pdf].

[58] P. Saucier et al., *Managed Long Term Care*.

[59] [http://www.texmed.org/Template.aspx?id=2596].

[60] [http://www.pai-ca.org/PublicAffairs/June13memo.pdf].

on nursing facility services, or if they have concerns that the negotiating power of the plan would lower payment rates.

Attractiveness of Managed Care to Beneficiaries

As described earlier, Medicare beneficiaries generally can voluntarily choose whether to enroll in Medicare managed care. States offering integrated Medicare/Medicaid programs have either voluntary enrollment or mandatory Medicaid enrollment with incentives to voluntarily enroll in a companion Medicare managed care plan. In Massachusetts, certain Medicaid benefits (e.g., vision, dental) maintained in the Medicare/Medicaid integrated Senior Care Options program were cut from the fee-for-service program, making the integrated Medicare/Medicaid program more attractive to beneficiaries.[61]

Some possible concerns of dual eligibles about joining a managed care program may include (1) the limitations to an individual's choices and flexibility in the services he or she receives; (2) the expertise of the managed care plan about disability and chronic conditions; (3) the breadth and scope of covered benefits; (4) the continuity with existing physicians/service providers; and (5) the concern that the plan's financial incentives for savings will ultimately result in limiting services and quality.

Policy Considerations for Congress

Looking at the challenges in developing integrated Medicaid and Medicare programs, there may be opportunities for further policy exploration. It should be noted that action in any of these areas would need to be weighed against prevailing fiscal constraints, efforts to ensure fiscal accountability (since service-specific utilization information may be less available under managed care), and possible conflicts with other important societal goals (such as maintaining beneficiary choice over his or her health care provider). With these qualifications, the following are offered as brief illustrations of policy options that Congress could consider as part of its interest in and oversight of this area:

- conducting evaluations and developing recommendations for regulatory and/or statutory changes;
- adding statutory language or explicit waiver or demonstration authority, to both Medicaid and Medicare law to allow for these types of programs under a single authority;
- giving states the option to require dual eligibles to enroll in managed care projects that integrate with Medicare through a Medicaid state plan option;
- streamlining federal oversight and/or administration of these demonstrations to avoid conflicting requirements;
- providing development grants and technical assistance to states;

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[61] P. Saucier et al., *Managed Long Term Care*.

- minimizing existing financial disincentives for providers to participate in managed care (e.g., phasing out UPL payments, providing supplemental funds through managed care savings, or minimzing the financial risk providers assume in the PACE program); and
- addressing financial disincentives for states (e.g., exploring alternative definitions of cost-effectiveness and budget neutrality in waivers for Medicare/Medicaid integration projects, or sharing any cost savings with both the Medicare and Medicaid programs).

Legislation

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171), enacted on February 8, 2006, established a PACE Provider Grant Program. Section 5302 of the bill creates site development grants, provides technical assistance to established rural PACE providers, and establishes an outlier fund for rural PACE providers. Grants of no more than $750,000 each will be awarded by the Secretary to 15 qualified PACE rural providers or pilot sites. DRA also requires the Secretary to establish a technical assistance program to provide (1) outreach and education to specified entities interested in starting rural PACE programs, and (2) technical assistance necessary to support rural PACE pilot sites. An outlier fund for inpatient and related physician and ancillary costs incurred for an eligible participant within a given 12-month period is required. The Secretary is appropriated $10 million for FY2006 through FY2010 (amended by P.L. 109-432) for the outlier fund. The Secretay is also required to submit a report to Congress on the evaluation of the rural PACE pilot sites.

Several bills have been introduced during the last several Congresses to encourage the development of integrated Medicare/Medicaid programs. For example, in the 109th Congress, Senator Grassley introduced S. 1602, the *Improving Long-Term Care Choices Act of 2005*, which included provisions to require the Secretary of the Department of Health and Human Services to consult with stakeholders and issue regulations to remove administrative barriers to integration of Medicare and Medicaid for dual eligibles. The legislation also would have required the Secretary to submit recommendations to Congress on how to remove statutory barriers to integration. This bill was referred to the Senate Finance Committee.

In the 108th Congress, the Medicare Special Needs Plan was enacted as part of the MMA. In addition, Senator Baucus introduced S. 2562, the *Medicare Quality Improvement Act of 2004*, which would have required the Medicare Payment Advisory Commission (MEDPAC) to study and report on care coordination programs for individuals dually eligible for Medicaid and Medicare. The study and report were to include the impact of care coordination programs on beneficiaries, and on the cost and savings to Medicare and Medicaid, including whether "any savings from care coordination programs are counted as a benefit to either program." This bill was referred to the Senate Finance Committee.

In the 106th Congress, Representative Stark introduced H.R. 4981, the *Chronic Illness Care Improvement Act of 2000*. This legislation would have added specific waiver authority under Medicare and Medicaid to establish coordinated, integrated

projects for dual eligibles. This provision would have allowed Medicare managed care rules to be waived to permit greater coordination with Medicaid, and would have mandated that the cost-effectiveness test be evaluated using the cost and savings attributable to both the Medicare and Medicaid programs. This bill was referred to the House Subcommittee on Health and Environment.

Appendix. States With Legislative Action to Consider or Enact an Integrated Medicare/Medicaid Program

California

The California state budget for 2005 and 2006 proposed an integrated Medicaid and Medicare program for dual eligibles. The program would have been piloted in three counties in the state. The 2005 proposal resulted in significant concerns by the county-based in-home support providers. The revised 2006 budget proposed an integrated Medicare/Medicaid managed care plan that does not include county-based in-home support services.[62,63]

Florida

As part of Florida's efforts to restructure its Medicaid program, the state is also developing an integrated managed care program for the elderly. In January 2006, Florida submitted a Medicaid waiver application to CMS to create the Florida Senior Care program, which would contract with managed care programs to provide all Medicaid services, cover all Medicare co-payments and deductibles, and coordinate with Medicare services. Florida Senior Care would be piloted in two areas of the state, and would enroll most Medicaid beneficiaries aged 60 or older. One pilot area would have mandatory enrollment; the other would have voluntary enrollment.

At this point, it is unclear to what extent the managed care plans will also become Medicare Advantage plans. If the plans become MA plans, additional integration may occur at the plan level (similar to the Texas Star+Plus program).[64]

Maryland

In August 2005, the Maryland Department of Health and Mental Hygiene (DHMH) submitted a Section 1115 waiver request to the federal government to create a new Medicaid program, called CommunityChoice, to develop a managed care program for the elderly and people with disabilities. This program would initially be piloted in two areas of the state, with an expected enrollment of 50,000.[65] The program would be mandatory for certain groups of individuals who live in the pilot areas, including dual eligibles, Medicaid beneficiaries aged 65 and over, and individuals who need long-term care services (except those enrolled in PACE or the

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[62] [http://www.dhs.ca.gov/mcs/mcpd/MCReform/PDFs/Acute%20and%20Long%20Term%20Care%20Integration%20Final%203-23-05.pdf].

[63] [http://www.caalz.org/2006-2007_budget.htm].

[64] [http://ahca.myflorida.com/Medicaid/long_term_care/pdfs/senior_care_program_waiver_press_release_012506.pdf].

[65] T. Engelheart, *The Maryland CommunityChoice Program*, Presentation to the PACE spring policy forum, May 1, 2006.

Medicaid home and community-based waiver for people with developmental disabilities).

The CommunityChoice program would include primary, acute, and long-term care services, with a goal of coordinating Medicare funding for dual eligibles. To facilitate coordination with Medicare, all CommunityChoice plans would be required to be licensed as Medicare Advantage Plans. Participants may then choose to receive both their Medicaid and Medicare services from one organization. Administratively, certain requirements of the CommunityChoice program would mirror Medicare Advantage program requirements to avoid duplication.[66]

[66] [http://www.dhmh.state.md.us/mma/communitychoice/].