



Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans

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ABSTRACT: Medicare Advantage Special Needs Plans (SNPs) for dual eligibles—individuals who qualify both for Medicare and Medicaid benefits—have the potential to coordinate Medicare benefits with state-administered Medicaid benefits. States that aim to develop such programs may choose from among three potential models: 1) a Medicaid program in which the beneficiary voluntarily enrolls in a single managed care organization (MCO) that delivers both Medicaid and Medicare services; 2) a program in which the beneficiary is required to enroll in a Medicaid MCO but retains freedom of choice regarding whether to enroll in a capitated Medicare plan; and 3) an administrative services organization approach, in which Medicaid retains a vendor to coordinate Medicaid services with the SNPs operating in the state. The authors also provide guidance on contractual issues important to state Medicaid agencies, and they discuss environmental factors that influence the choice of models and the program’s prospects for success.



Overview

The Medicare Advantage Special Needs Plan (SNP), a new type of plan authorized by the Medicare Modernization Act of 2003, offers an unprecedented opportunity to improve the coordination of Medicare and Medicaid benefits for the roughly 7 million individuals who are eligible for both programs (“dual eligibles”). In targeting the dual-eligible population, SNPs may partner with state-administered Medicaid programs to provide beneficiaries with a more comprehensive package of acute care and long-term services. Unnecessary, inappropriate, or inefficient care might be averted, and higher-quality care and better outcomes

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for the beneficiary should result. (Dual-eligible SNPs are described in detail in the companion Commonwealth Fund issue brief, *Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer*).

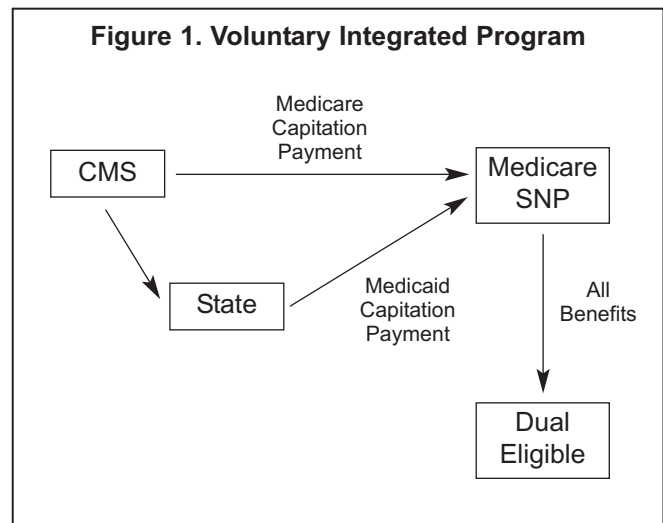
Federal law gives Medicare beneficiaries the right to choose the institution, agency, or individual that provides their Medicare benefits.¹ This Medicare “freedom of choice” enables individuals to receive services in a Medicare fee-for-service delivery model or instead to enroll in a regular Medicare Advantage plan or a Medicare Advantage SNP. But coordinating a dual eligible’s Medicare and Medicaid benefits requires a mechanism that spans both programs—a formal relationship between the dual eligible’s Medicare plan and the state program through which the dual-eligible beneficiary receives his or her Medicaid benefits. A SNP could be this mechanism. However, SNPs and states must have a shared interest in coordinating Medicare and Medicaid benefits at the individual level and structuring the program in such a way that beneficiaries will see clear advantages to voluntarily enrolling.²

This issue brief presents three different models—none mutually exclusive—that states could utilize to link Medicaid programs with SNPs. The discussion includes the models’ advantages and disadvantages, practical guidance on contractual issues important to state Medicaid agencies, and environmental factors that may influence a state’s choice of models and the program’s ultimate success.

The first model is a voluntary Medicaid program that permits a dual-eligible beneficiary to enroll in a single managed care organization (MCO) that receives capitation payments to deliver both Medicaid and Medicare services to the individual. The second model is a mandatory Medicaid program in which the dual-eligible beneficiary is required to enroll in a Medicaid MCO, while the person retains freedom of choice regarding whether to enroll in a capitated Medicare plan. The third model is an administrative services organization (ASO) approach in which Medicaid retains an administrative vendor to coordinate the delivery of Medicaid services with the SNPs operating in the state.

Model 1: Voluntary Integrated Program

In this model, dual-eligible beneficiaries who choose to enroll in a SNP for their Medicare benefits also voluntarily enroll in the same health plan to receive Medicaid benefits.³ In effect, a single MCO holds one capitated contract with the state Medicaid agency to deliver Medicaid services and a separate capitated contract with the U.S. Centers for Medicare and Medicaid Services (CMS) to deliver Medicare services as a SNP. Because a single organization bears the responsibility, and financial risk, for the dual-eligible beneficiary’s benefits in both programs, it has an incentive to coordinate care so that prevention and other positive outcomes are promoted. Figure 1 illustrates this model.



Minnesota Senior Health Options (MSHO), begun in 1997, exemplifies a voluntary program for dual eligibles.⁴ Until now, participating MCOs have received a single combined capitated payment for each beneficiary (across both Medicare and Medicaid services). Massachusetts Senior Care Options, implemented in 2004, is another voluntary program in which the MCOs received a single payment for services both from Medicare and Medicaid.

The Minnesota and Massachusetts programs are now in transitional stages, as the Medicare payment waivers that undergirded both programs are expiring and they are shifting to a SNP-based structural model. That is, a single plan will receive two separate payments:

one from Medicare, derived from the Medicare Advantage risk-adjusted payment methodology, and a separate Medicaid payment from the state, based on Medicaid's rules that require "actuarially sound" payment rates. The new model in Minnesota and Massachusetts could be replicated in other states and markets, as they will no longer be based on the special Medicare waivers that those two states received. New York, Washington, and Wisconsin are already offering a version of this model, and other states are at various stages of planning and implementation.

On the Medicare side, this model is premised on an arrangement in which the MCO holds a Medicare Advantage SNP contract and is responsible for delivering all Medicare-funded services—including Part D prescription drugs and any supplemental Medicare benefits approved by CMS in the SNP bidding process. The rate structure mirrors 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 needs to secure a capitated contract with the state Medicaid agency that includes a per-person-per-month payment to the MCO for Medicaid-funded services. In determining that payment, certain state-specified risk-adjustment factors are taken into account, ranging from simple (age, gender, nursing-facility level of care or not) to more complex. For example, Massachusetts chose to pay a higher rate for enrollees with a dementia diagnosis. And Minnesota chose to carve out very long nursing-facility stays from the capitation payments to the MCOs—partly because of the difficulty an MCO would have in managing a resident's care or transitioning the resident to a less-expensive community setting, and partly because of political considerations related to the nursing-home industry's concerns about capitation.

Working with the Center for Health Care Strategies (CHCS) and others, CMS is developing policies and procedures across Medicare and Medicaid to improve the viability of this type of integrated voluntary program. At the same time, it is attempting to

retain the blended-financing features that Massachusetts, Minnesota, and Wisconsin were able to deploy under their expiring Medicare waivers.⁵ For example, CMS is working with CHCS and a number of states and interested parties to develop mechanisms that coordinate, across Medicare and Medicaid, functions such as program marketing, enrollment, services, financing, data management and sharing, Medicare supplemental benefits, and quality assurance.⁶

Because participation in these programs is entirely voluntary for dual eligibles, achieving a high level of enrollment ("scale") is dependent both on a good model of care and on effective outreach to prospective enrollees. Once taken to scale, a program should have diverse enrollment, an extensive provider network, and operational economies of scale; and it should offer optimal access, quality, and coordination of services across Medicare and Medicaid.

In going forward with a voluntary program under Model 1, a state must typically weigh the likelihood of moving to scale against the 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). 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 of dual eligibles from across all acuity levels (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 marketing effort with Medicaid that targets each subpopulation of dual eligibles.

Assuming that it is in the state's interest to encourage dual eligibles to enroll in this coordinated system of care, it should design the program to include features that dual eligibles would value—such as promotion of community-based care as an alternative to institutions, and active care coordination.

A full array of community-based long-term-care supports and services—e.g., home renovations, a one-time purchase of special equipment, and transition resources for moving from an institution back to the community—could be of substantial help in enabling an individual to remain in 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, are key to the effectiveness of these programs. Care management in a capitated program is more often driven by medical management than revenue management as in a fee-for-service program.

Care coordination must be structured to cut across traditional Medicare–Medicaid service boundaries so that the two programs’ services are delivered in the best overall way—that is, with good health outcomes, high consumer satisfaction, and overall cost-effectiveness and with incentives to reduce avoidable hospital stays (thereby saving Medicare funds) and reduce avoidable long-term nursing-home stays (which saves Medicaid funds). 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 a reasonable alternative to (or an addition to) Medicare home health. Along with reducing unnecessarily long lengths of stay, a well-run program should provide more effective hospital and nursing-home discharge services and encourage person-centered community-based care.

Transparency in pricing will be important to the state. Because it 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 for entering into a state contract.

With the “bundled” package of Medicare and Medicaid services offered by these integrated programs, information about the delivery of Medicare services also should be sought by states as a condition of a

Medicaid contract. Utilization data will also be useful to ensure quality and inform rate-setting.

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

Model 2: Mandatory Program, with Potential Side Agreements

This model involves a program in which a dual eligible is required to enroll in a capitated Medicaid managed care program administered by an MCO, even as the person is at liberty to choose whether to participate in a capitated Medicare program. The model has now been implemented in Arizona and Texas.⁷ States pursuing Model 2 typically impose, as a condition of receiving a Medicaid contract with the state, that an MCO also be approved in the state as a SNP. Thus the possibility that a single entity might serve as both the dual-eligible beneficiary’s Medicaid MCO and as his or her Medicare SNP is retained.

There are three possible outcomes for a dual-eligible beneficiary if the state pursues Model 2:

- The beneficiary remains in Medicare fee-for-service, in which case the person’s Medicaid MCO must coordinate the contractual Medicaid benefits with his or her Medicare benefit providers.
- The beneficiary chooses to enroll in the SNP that also serves as his or her Medicaid MCO.
- The beneficiary enrolls in two separate MCOs—he or she selects a Medicare Advantage plan (perhaps even a SNP) that is not the same health plan as the person’s Medicaid MCO. Thus the two separate health plans need to coordinate with one another.

Clearly, the ideal scenario in this mandatory program model is enrollment in the same high-quality

health plan both for Medicare and Medicaid benefits—an outcome that resembles Model 1.

Even when the dual-eligible beneficiary is *not* enrolled in the same health plan for both sets of benefits, coordination of care can still occur in a manner that improves quality, access, and coordination for the individual. For example, as depicted in Figure 2, the state can establish a separate “side agreement” with Medicare SNPs operating in the state. Failing that, Medicaid MCOs and Medicare SNPs might establish side agreements amongst themselves to engage in, for example, electronic health-record data sharing, service-data sharing, coordination about discharges, alerts about changes in enrollee health status or other risk factors, and coordination of benefits. These kinds of side agreements are not prevalent in, for example, the Arizona and Texas programs, but they would represent a vast improvement.

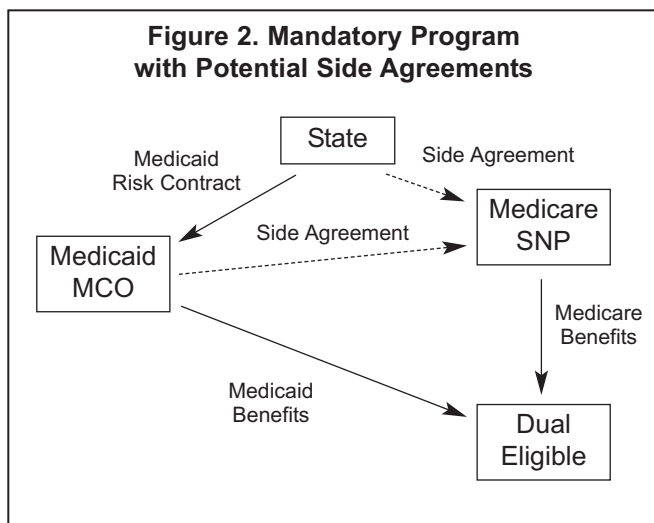
facility (such as physician-assistant or nurse-practitioner services) to avoid unnecessary Medicare-covered hospital admissions.

Ideally, this process would be directed by the state, which could compel each Medicaid-contracted MCO to provide it with certain data. The state would then make this information available to SNPs through a side agreement that included the necessary patient-confidentiality protections. The state might also seek to enter into mutually advantageous contracts with non-Medicaid contracted health plans operating as approved SNPs in the state. Once the side agreements were created in this manner, the state could act as a clearinghouse so that all the Medicaid-contracting MCOs and all the Medicare Advantage SNPs operating in the state could share data on enrollees common to the health plans. Provided that the data-sharing was sufficiently robust and timely, positive health and service outcomes could be achieved even when the dual-eligible beneficiary was not enrolled in a single plan both for Medicare and Medicaid.

Alternatively, health plans could establish these side agreements amongst themselves, without the state’s involvement. This outcome is less desirable in that the state wouldn’t have access to Medicare-related data useful in designing and improving its administration of Medicaid services for dual eligibles. Still, if the state is not pursuing this role, the plans are free to form their own contractual relationships.

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, and coordination of benefit arrangements. Moreover, the agreements could include procedures for identifying and assessing needs and for 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 enable the plans and the state to more effectively monitor access to care, the



Side agreements could be the basis for contractual arrangements between Medicaid MCOs and SNPs. For example, a Medicaid MCO would want to know when a beneficiary is admitted to a hospital for a Medicare-covered service. A contract with each of the state’s SNPs could require the SNPs to provide this information to the MCO. Similarly, the SNP would want to know when the beneficiary was admitted to a nursing home for a Medicaid-covered stay, as it might wish to actively provide supports in the nursing

adequacy of provider networks, compliance with performance measures, coordination of benefits to ensure that the proper program delivers a given benefit, experience with disease-management programs, and financial performance. The health plans and the state would also be able 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 Michael O. Leavitt, Secretary of the U.S. Department of Health and Human Services.⁸

Also, responsibility for payment of Medicare “crossover claims”—e.g., Medicare Part B premiums, annual deductibles, and coinsurance for physician visits and hospital stays—could be specified in the side agreements. Medicaid is responsible for these costs, but the state would want to consider whether to directly pay providers for these expenses or to include funds for these payments in the beneficiary’s capitation payment. In deciding, the state would want to weigh ease of administration, whether the amounts of the crossover payments were sufficiently predictable to capitate, and other factors.

As with Model 1 (the voluntary integrated program), states and health plans pursuing Model 2 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 care, for example, because the Medicaid MCO believed that Medicare should cover it, while the SNP believed it was not a Medicare-covered service and the Medicaid MCO should therefore cover it. A mechanism for resolving such cross-program coverage disputes, in a beneficiary-centered way, is crucial to effective programs that coordinate care.

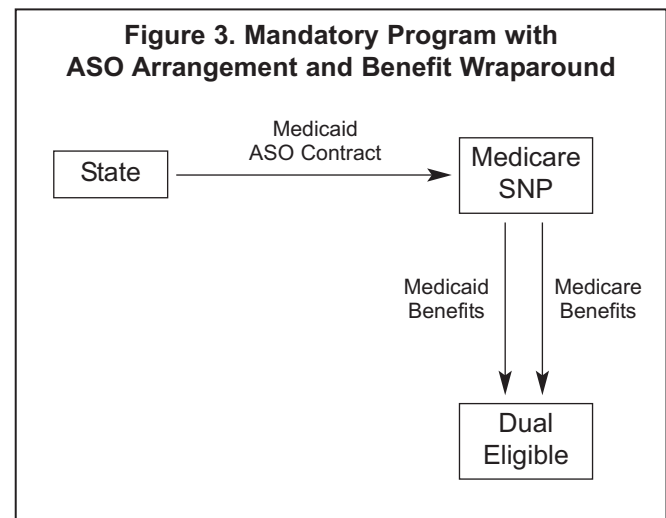
In order to obtain approval to operate a mandatory Medicaid managed care program, a state needs to secure a waiver, such as a Section 1115 federal Medicaid waiver or a combined Section 1915(b)(c) Medicaid waiver [the 1915(b) authorizes mandatory

managed care and the 1915(c) allows financing for Medicaid home- and community-based services]. New authority created by 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 was initially approved in 1997.⁹ New Mexico has a Section 1915(b)(c) waiver pending approval by CMS, and several other states are now considering mandatory programs utilizing this combination waiver as well.

Model 3: Program with ASO Arrangement

This model involves an administrative services organization (ASO)—a vendor retained by Medicaid to coordinate the delivery of Medicaid services with the Medicare Advantage SNPs operating in the state. That ASO could be one or more of the dual-eligible SNPs themselves—an arrangement that would enhance the prospects of effective coordination—but the ASO could also be an entirely unrelated entity, as long as it had competencies in administrative services and coordination of care (Figure 3). This approach to coordination between Medicaid and Medicare would not involve a managed care program, nor would it require



a federal Medicaid waiver—each ASO contract would be purely administrative (like a fiscal-agent contract or a utilization-review contract).¹⁰ Payment for services would not be based on financial risk but rather on an administrative fee for delivering the state’s Medicaid fee-for-services benefits through its existing provider network.

The state could execute ASO arrangements with any of its SNPs, which would then be responsible for administering state Medicaid wraparound services for any dual eligibles who enroll. The ASO arrangement would not alter existing Medicare and Medicaid benefit packages, nor would it affect the provider networks offered separately by Medicaid and the SNP. As an ASO, the SNP’s role in providing Medicaid benefits would involve purely administrative activities—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, and reviewing and approving plans for long-term care—as defined by its contract with the state. The ASO’s role in administering Medicaid would be invisible to beneficiaries, just as they are largely unaware of the company retained by a given state to serve as Medicaid claims-processing fiscal agent or Medicaid utilization-review contractor.

In this arrangement, the SNP would essentially perform “back office” functions for Medicaid. Yet the result would likely be improved coordination of care for dual eligibles, given that the SNP, in its role as the entity that reviews and approves claims, *would have a complete awareness of the Medicaid-funded services*. The SNP could thus coordinate the Medicaid benefits it was managing on behalf of the state with the Medicare benefits it was 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 chose to include, such as marketing, beneficiary 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 that it would need to exercise oversight.

The state would likely pay the SNP an administrative “case management” fee for each Medicaid member. This fee could be an agreed-upon dollar amount per member per month, or it could be based on a percentage of the Medicaid dollars handled by the organization. In a 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.

Because the state pays Medicaid claims on a fee-for-service basis—no capitated payments are involved—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 having no prior experience with a state’s Medicaid program to begin doing business in that state. The SNP would gain knowledge about the state’s Medicaid program, its nursing-home industry, its panel of Medicaid fee-for-service providers, the availability of community-based long-term supports and services, and the infrastructure for supporting expanded community-based services (e.g., housing, labor, and state policies). The SNP would also be able to begin building a provider network for Medicaid beneficiaries.

One major risk in an ASO arrangement, however, is the 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 might not be at financial risk under Medicaid, unrestrained approval of Medicaid-covered services would not affect its bottom line. Moreover, the entity could use its knowledge gathered from Medicaid claims (diagnoses as well as utilization information) to cherry-pick Medicare enrollees for its SNP. States could address this issue in a number of ways, including randomly

auditing the ASO's approvals (much like states audit providers to avoid excessive billing), utilizing incentive bonuses (where the ASO would be paid a bonus based on reducing unnecessary services), and through active contractual oversight (similar to state oversight of MCOs to prevent inappropriate denials of care in a capitated program).

Factors Influencing the Choice of Models

States that have managed-care experience or a preference for managed care will be more likely to pursue Model 1 or Model 2, with ease of implementation being a key factor. For example, Model 2 requires CMS's approval of a Medicaid managed care waiver, which can be a long and arduous process. Model 1 requires approval of a voluntary capitation program for Medicaid [usually under 1915(a)], but this does not involve a waiver. Meanwhile, Model 3 requires no federal waiver or major approval procedure, beyond the approval process for administrative vendor contracts.

Because it is a voluntary program, Model 1 could be difficult to bring to scale and build sustainable levels of enrollment. Projected enrollment will be a major factor in a SNP's decision to partner with the state, as enrollment will directly affect provider participation, market penetration, operating efficiencies, and margins. Nevertheless, Model 1 might be the optimal model for a SNP if managed Medicare is not well established in the state and providers and beneficiaries are strong proponents of Medicare fee-for-service. But if managed Medicare is trusted and established in the state, the SNP may prefer Model 2, as dual eligibles are 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.

Enrollment will affect preference for Model 1 or 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 as an 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. Side agreements to enhance care coordination would improve the effectiveness of Model 2.

The prospects of Models 1 and 2 are dependent on effective marketing campaigns and enrollment systems, but such techniques can only go so far. Beneficiaries must envision *and then experience* a clear benefit in the services offered by these programs. It is also important to note that long-term success of either Model 1 or Model 2 will be dependent on developing a sound risk-adjusted methodology for setting Medicaid capitated payment rates.

Model 3 is an option for states having limited experience with or interest in capitated Medicaid managed care. States in which few SNPs operate, or SNPs are not geographically dispersed, are also good candidates for this model. In addition, states with existing ASO relationships might consider Model 3. And the model 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. This is because in Model 3 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 for services, the choice to use an ASO would not result in a lower federal match, whereas a poorer state with a higher service matching rate would lose out by utilizing the administrative matching rate instead.

The choice of model and ease of implementation will also be influenced by the environment within the state. Budgetary pressures and the extent to which the governor, legislature, and citizen-advocates are pushing Medicaid reform and managed care will have

a direct influence on model choice. Prior successful collaboration on program development by the state’s Medicaid, aging, and disabilities agencies is important as well. And data-sharing arrangements will be critical for all three models, but especially for Model 1 and Model 2.

Final 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 efficient community-based care and reduce unnecessary hospitalizations and nursing-home stays. Yet to date, as described in our [companion issue brief](#), most of the 320 SNPs approved by CMS to serve dual eligibles are providing Medicare services only, despite the fact that many state Medicaid agencies are actively seeking to collaborate with SNPs. For those Medicare and Medicaid plans that do coordinate their services, it will be important to document their experiences with the three models and in particular to determine the impacts on the cost and quality of dual eligibles’ care.

Medicare) 84 percent of Medicaid spending for dual eligibles is for long-term care.

Prior to enactment of the MMA, only a few coordinated models of care for dual eligibles were in existence. These models included voluntary Medicaid managed care programs in Minnesota and Wisconsin, mandatory Medicaid managed care programs in Arizona and a region of Texas, and small sites in several regions that were Programs for All-Inclusive Care for the Elderly (PACE) facilities. See A. Sommers, M. Cohen, and M. O’Malley, *Medicaid’s Long-Term Care Beneficiaries: An Analysis of Spending Patterns* (Kaiser Commission on Medicaid and the Uninsured, Nov. 2006).

- ³ A beneficiary’s participation in Medicare managed care is always voluntary. When the terms “voluntary” and “mandatory” are used in this report, they refer to individuals’ participation in Medicaid managed care.
- ⁴ 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.
- ⁵ 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.
- ⁶ 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.
- ⁷ Florida applied for and received the necessary federal waivers to begin a mandatory program, but in late 2007 Florida elected not to implement a mandatory program, and instead will proceed with a voluntary program in two regions.
- ⁸ National Governors Association. Letter to The Honorable Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services. Feb. 12, 2007. Available at <http://www.nga.org/portal/site/nga/menuitem.cb6e7818b34088d18a278110501010a0/?vgnnextoid=b36368325b6b0110VgnVCM1000001a01010aRCRD>.
- ⁹ Florida’s program was approved with a mandatory 1915(b)(c) combination waiver, before the state chose to proceed with an entirely voluntary program instead.
- ¹⁰ As a result, the fees paid to the ASO would be matched at the federal government’s administrative Medicaid matching rate, not at 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.

NOTES

- ¹ Section 1802 of the Social Security Act.
- ² In general, dual eligibles have not been enrolled in the large, traditional capitated Medicaid managed care programs for acute services. 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. Thus, it is not easy for a Medicaid MCO to 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

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