State Guide to Integrated Medicare & Medicaid Models

March 2006

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Executive Summary

Most dual-eligible beneficiaries are subjected to fragmented health care delivery systems in which they seek health care with their Medicare and Medicaid coverage entitlements. Depending upon the State in which a dual eligible resides, the delivery system may combine fee-for-service and/or managed care. In situations in which the integration of Medicare and Medicaid delivery is possible and available, dual-eligible beneficiaries can experience better care coordination and fewer administrative burdens.

Section 231 of the Medicare Modernization Act (MMA) established an option for private Medicare Advantage Plans ("MA Plans") to exclusively or disproportionately enroll "special needs" individuals. MA Plans that do so are referred to as "Special Needs Plans" (SNPs). Three groups of special needs individuals are specifically identified in the MMA: the institutionalized, those with Medicare and Medicaid coverage (a.k.a. "dual eligible beneficiaries" or "dual eligibles"), and chronic disease plans as may be approved by CMS. Thus, SNPs may offer an opportunity to better integrate Medicaid and Medicare coverage for dual eligible beneficiaries. For more information go to http://www.cms.hhs.gov/SpecialNeedsPlans

There are four models that States and managed care plans have used in recent years to integrate Medicare and Medicaid services. These models, discussed below, vary in the degree to which they integrate services covered by the two programs. This guide was developed to address some of the difficulties States face in attempting to integrate Medicare and Medicaid coverage and to help plans and States develop more integrated models, such as through the use of SNPs, for dual eligible beneficiaries.

Model 1: Buy-In Wraparound Model - The "Buy-In Wraparound Model" partially integrates Medicare and Medicaid services. In this model, States encourage Medicare Advantage organizations ("MA organizations") to provide Medicaid benefits through a Medicare supplemental benefit package which the MA Organization offers to Medicare beneficiaries enrolled in the MA Plan. The State then would opt to pay the premiums for the supplemental package in its Medicaid State plan. Because Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Medicare Beneficiaries (QMB), Qualifying Individuals (QI) and Qualified and Disabled and Working Individuals (QDWI) are not eligible for the wraparound Medicaid services provided under the supplemental benefit package, they would have to pay the supplemental premium in order to receive these benefits. In this model, the State Medicaid Agency acts as a financing mechanism, but has no oversight of the MA Plan. (Note that some QMBs and SLMBs also may be eligible for full Medicaid benefits, in which case they would be eligible for the wraparound Medicaid services provided under the supplemental package. Such individuals commonly are referred to as "QMB-Plus" and "SLMB-Plus" beneficiaries. QMBs and SLMBs who are not also eligible for full Medicaid benefits commonly are referred to as "QMB-only's" and "SLMB-only's.")

Model 2: Capitated Wraparound Model - The "Capitated Wraparound Model" also represents a partial integration model, under which States enter into a companion Medicaid capitated contract with health organizations which also have regular MA or SNP plan contracts. Unlike Model 1, however, the State Medicaid Agency has a separate agreement with the organization, and oversees the Medicaid contract. Also unlike Model 1, the Medicaid contract, rather than the MA Organization's supplemental benefit package, defines the Medicaid benefits for beneficiaries eligible for full Medicaid coverage. The Medicaid

contract also can address payments for Medicaid beneficiaries eligible for Medicare cost-sharing assistance (e.g., QMBs). Because SLMB-only, QMB-only, QI, and QDWI beneficiaries are not eligible for full Medicaid benefits, individuals eligible for Medicare Part A and/or Part B premium assistance under these groups would have to pay the Medicaid contract capitated rate themselves in order to receive the Medicaid benefits. CMS administers this model like any other MA Organization.

Model 3: Three-Party Integrated Model - The "Three-party Integrated Model" is a fully integrated model in which the MA Organization, the State Medicaid Agency and CMS enter into a three-way contract. The provision of acute and long-term care Medicare and Medicaid services are integrated at the health plan level through the use of a single managed care entity, and Medicare and Medicaid financing are integrated through use of capitated payments to the organization. PACE and the dual-eligible demonstrations that are now MA dual eligible SNPs in Minnesota, Wisconsin, and Massachusetts are some examples of programs that utilize this model.

Model 4: Plan-Level Integrated Model - The "Plan-Level Integrated Model" is a fully integrated model in which the health organization chooses to integrate separate Medicare and Medicaid contracts, negotiates the terms of its Medicare and Medicaid contracts separately with CMS and the State, and itself develops a single set of policies and procedures for the enrolled dual-eligible populations addressing both Medicare and Medicaid requirements. Because neither the State nor CMS initiates this model, both the State and CMS treat this model like any other non-integrated model. While this approach may result in some duplication of oversight by the State and CMS, the organization may find that this approach is faster to implement.

Specific Issue Considerations for Each Model – As a State or an MA Organization, and CMS separately or together, attempts to develop an integrated delivery system, there are a variety of specific issue considerations that must be considered – issues that are inherent in attempting to integrate the health care delivery systems for two different statutory programs. The major specific issue considerations fall into the areas of enrollment, operations, benefits, payment, appeals, and MMA implementation. These and other issues are presented in the body of the report and discussed in the context of each model. Additional CMS guidance on the various models will be provided in future updates of this report.

Introduction

The purpose of this guide is to outline options that States may wish to consider when developing new Medicaid managed care contracts for dual-eligible beneficiaries. The guide is a tool for State personnel already involved in serving dual eligible beneficiaries. The guide is a starting point, a working document, which CMS hopes will stimulate improved performance and better value for serving dual eligibles through the creation of integrated service delivery systems for Medicare and Medicaid benefits, subject to the current statutory and regulatory environment in which each program operates. Each State will have to assess the viability of each model within the context of its own unique circumstances and political landscape in order to determine whether any of the models presented will work for its dual eligible population. Particularly, as MA SNPs become a widely available option across the nation, we expect that the concepts presented in this guide will need to be further examined and refined, as States delve into developing integrated service delivery systems for dual eligibles, tailored to the circumstances in their State, and as additional policy clarifications are issued by CMS. Any inquiries sparked by this guide should be directed to the appropriate CMS component. As always, CMS' Regional Offices represent the first point of contact for States interested in pursuing the development of an integrated service delivery system for their dual eligibles.

The guide was also developed to promote a regulatory environment that is conducive to integrating services provided by MA Organizations and Medicaid. The intent is to convey the possibilities of an integrated program that works within existing or proposed regulations, is valuable to dual-eligible beneficiaries, meets State Medicaid Plan objectives, and is marketable for MA Organizations. The objective is to outline the considerations of implementing an integrated Medicare/Medicaid environment to the extent possible under the existing and regulatory environment. Moreover, this guide aims to stimulate thought on the possibilities of efficacious, integrated Medicare/Medicaid plans for dual eligibles that meet the needs of States and MA Organizations.

Medicare Advantage Organizations, Plans, and Special Needs Plans Under the Medicare Modernization Act

Medicare and Medicaid sometimes attribute different meanings to similar terms, some of which have specific meanings in the Medicare Advantage and Medicaid programs. Below we define several terms with distinct meanings in the Medicare program, and give the corresponding Medicaid term where appropriate.

A Medicare Advantage Organization (MA Organization) is a public or private entity organized and licensed by the State as a risk-bearing entity (with the exception of provider-sponsored organizations or Regional MA plans receiving a waiver of this requirement) that is certified by CMS as meeting the MA contract requirements. This is similar to a Managed Care Organization (MCO) in Medicaid.

A Medicare Advantage Plan (MA Plan) is a health plan offered by an MA Organization that includes all Medicare covered health benefits, offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA Plan. This is similar to a specific State contract with an MCO in Medicaid. States can contract with an MA Organization to offer a supplemental benefit package covering Medicaid-only benefits.

A Medicare Advantage Special Needs Plan (SNP) is a new type of Medicare Advantage coordinated care plan created by Section 231 of the MMA that is focused on individuals with special needs.. Congress identified "special needs individuals" as Medicare beneficiaries that are (1) institutionalized; (2) entitled to medical assistance under a State plan under Title XIX (i.e., individuals that are dually eligible for both Medicare and Medicaid); and/or 3) determined by the Secretary as being able to benefit from enrollment in a SNP because of severe or disabling chronic conditions. Medicare reimbursement for SNPs is provided in the same manner as for any other type of MA Plan. The statutory authorization for SNPs to limit enrollment to special needs individuals currently expires January 1, 2009. MA SNPs must meet Medicare Advantage requirements, including application requirements, bids, and quality criteria. MA Organizations that offer a SNP may limit enrollment to MA eligible beneficiaries in any of the three target populations listed above, or they may create a plan that enrolls a greater percentage of one of these target populations than occurs nationally in the Medicare population. Additional parameters concerning each of the target populations for SNPs include:

Institutionalized Beneficiaries:

- Those who reside or are expected to reside continuously for 90 days or longer in a long-term care facility which is a Skilled Nursing Facility (SNF); Nursing Facility (NF); (SNF/NF); immediate care facility for the mentally retarded (ICF/MR); or inpatient psychiatric facility.
- Those individuals living in the community but requiring a level of care equivalent to that of individuals in one of the long-term care facilities described above. (as noted above).

Dually Eligible Beneficiaries:

- Beneficiaries must have Medicaid coverage at the time of enrollment;
- SNPs may enroll a subset of the dual eligible category, such as dual eligible beneficiaries entitled to full Medicaid benefits, as opposed to all dually eligible beneficiaries (i.e.,

including dual eligibles entitled only to assistance with Medicare cost sharing and/or premiums).

Beneficiaries with Chronic Conditions

- To provide as much flexibility as the law allows and because this is a new "untested" type of MA Plan, CMS did not set forth in regulation a detailed definition of severe and disabling chronic conditions;
- CMS will evaluate proposals on a case-by-case basis;
- CMS will consider appropriateness of target population; clinical programs and special expertise; other unique features of the SNP serving the proposed target population.

Health-Care Delivery Combinations for Dual Eligibles

Because the environment in which most dual eligibles seek coverage has two sets of rules for coverage (one for Medicare, another for Medicaid) the system can be confusing – not only to beneficiaries, but also to the health organizations providing care and benefits. Table 1 illustrates some (but not all) of the combinations of dual-eligible coverage.

Table 1: Delivery System Combinations for Dual Eligibles

Medicare	Medicaid
Fee-for-Service	Fee-for-Service
Managed Care	Fee-for-Service
Fee-for-Service	Managed Care
Managed Care Health Plan X	Managed Care Health Plan X
Managed Care Health Plan Y	Managed Care Health Plan Z

The term "dual eligibles" also embraces a range of beneficiaries, who enjoy different Medicaid benefits – from full Medicaid benefits to full or partial assistance with Medicare premiums and/or cost-sharing charges. The following chart shows the different categories of dual eligibles, illustrating that even in a duals-oriented Medicare/Medicaid model the category of dual eligible affects the services and benefits that may be provided in an integrated model.

Table 2: Categories of Medicare/Medicaid Dual Eligibles

	Type of Medicaid Benefit			
Dual-Eligible Category	**Part A Premium**	**Part B Premium**	**Medicare cost-sharing**	**Full Medicaid Benefits**
Eligible for Medicaid, and for Medicare Part B through a State Buy-in	No	Yes	[stet] No [1]	Yes
QMB not eligible for full Medicaid	Yes	Yes	Yes	No
QMB eligible for full Medicaid	Yes	Yes	Yes	Yes
SLMB not eligible for full Medicaid	No	Yes	[stet] No	No
SLMB eligible for full Medicaid	No	Yes	[stet] No	Yes
QI	No	Yes	No	No
QDWI	Yes	No	No	No

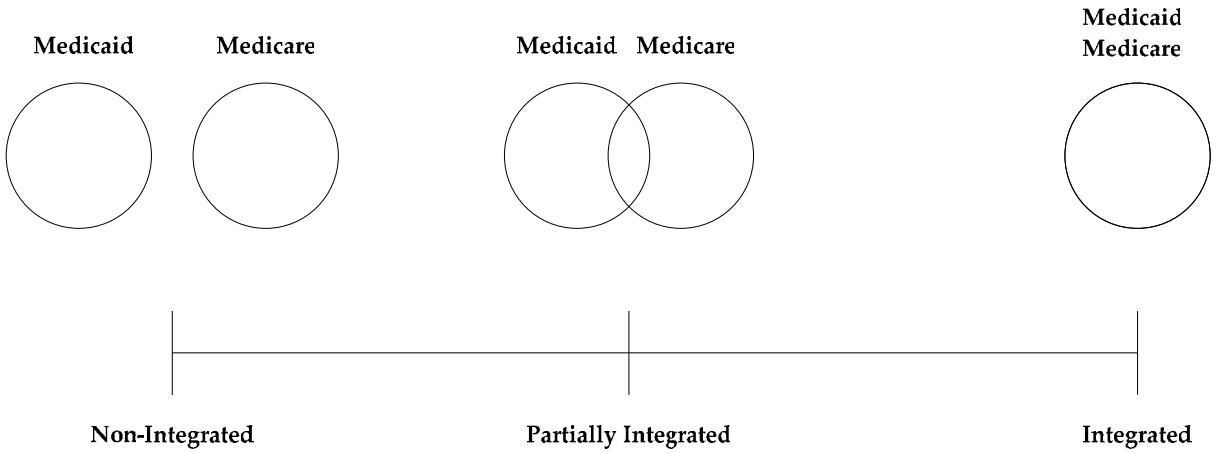
QMB Qualified Medicare Beneficiary
SLMB Specified Low Income Medicare Beneficiary
QI Qualifying Individual
QDWI Qualified Disabled and Working Individual

[1] In the case of an individual eligible only for Medicaid who is enrolled in Medicare Part B because the State pays the premium, Medicare cost-sharing would not be covered as "cost-sharing." However, if the services in question are services covered under the State plan, the State is obligated to pay costs not covered by Medicare, other than the nominal Medicaid cost-sharing amounts that may be collected for under the State plan for Medicaid-covered services. This same analysis would apply to the fifth category on this chart, a SLMB who is eligible for full Medicaid benefits.

Dual-Eligible Medicare and Medicaid Provider Integration Continuum

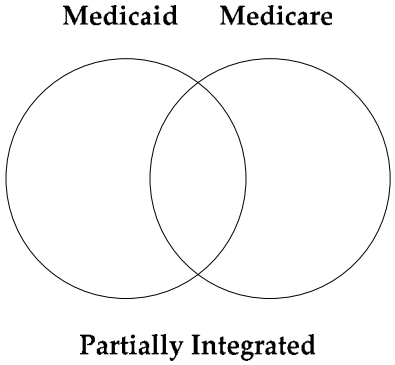
To assist in understanding the models, Figure 1 shows a continuum of the various models, starting from non-integrated models and moving to integrated models. This graphic depiction shows the level of integration of each of the models. This guide focuses on four models: two partially integrated models and two integrated models. While the guide does not discuss any non-integrated models (e.g., Medicaid managed care plans combined with Medicare fee-for-service or an MA Organization combined with Medicaid fee-for-service), the full continuum is helpful in understanding the distinctions among the models.

Figure 1. Dual-Eligible Medicare and Medicaid Provider Integration Continuum.



Model 1: Buy-In Wraparound Model

Figure 2. Partially Integrated Point on the Continuum for Buy-In Wraparound

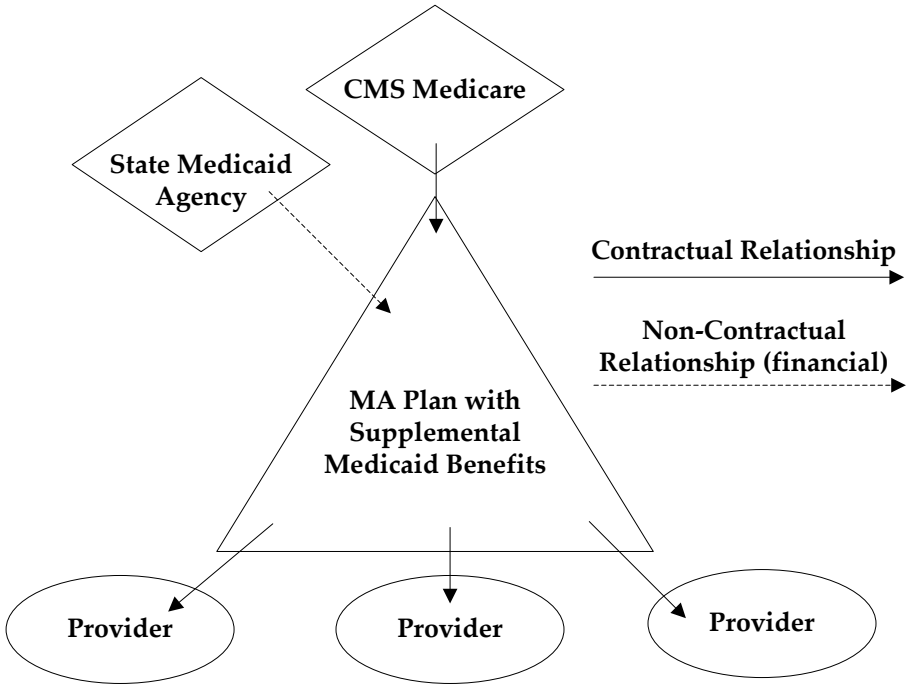


The "Buy-In Wraparound Model" is a partially-integrated model. Under this option, the State would encourage MA Organizations to offer all Medicaid services under an MA Plan, which would provide the Medicaid benefits through a Medicare supplemental benefit package. The State would then opt to pay the premiums for both the basic and supplemental benefit packages offered by the MA Plan. (States have the option under section 1905(p)(3) of the Social Security Act to cover the premium associated with Medicare-covered benefits for QMBs enrolled in an MA Plan. For dual eligibles entitled to full Medicaid benefits (including QMB-Pluses) States can opt to cover the premiums associated with Medicaid-covered benefits provided that the State can demonstrate that it is cost-effective for it to do so. Because QMB-only, SLMB-only, QI and QDWI-eligible individuals are not eligible for the wraparound Medicaid services provided under the supplemental benefit package, they would have to pay the supplemental premium in order to receive these benefits.

In this model, the State Medicaid Agency serves as a financing mechanism and exercises no oversight over the MA Plan. However, to the extent that the Plan does not cover a Medicaid service, Medicaid would continue to provide wraparound coverage for dual eligibles entitled to full Medicaid benefits, and the State Medicaid Agency would retain oversight over such wraparound coverage, including the provision of Medicaid hearing and appeal rights of adverse decisions relating to such coverage.

Graphically, the Buy-In Wraparound Model can be depicted as follows:

Figure 3: Buy-in Wraparound Model



Policy Considerations for the Buy-In Wraparound Model

In this model, the MA Plan(s) would offer a supplemental benefit package covering the Medicaid benefits covered by the State, in addition to the Medicare basic benefit package. The State would then pay the premium associated with the supplemental benefit package for dual eligibles with full Medicaid benefits. States are not obligated under Medicaid to pay the premium associated with any regular benefits provided to dual eligibles enrolled in an MA Plan, unless the State has elected to do so in its State plan. If the State does not elect to pay such premiums, dual eligibles must pay the premium themselves in order to enroll in the plan and receive benefits. Therefore, in order for this model to be attractive to dual eligibles, the State may need to elect to pay premiums for enrollment in an MA Plan under its State plan.

The State also could pay a negotiated per capita payment to cover Medicare sharing for any QMBs enrolled in an MA Plan. Doing so would address two complaints raised by States: (1) Because MA Plans can charge different cost-sharing obligations on their members than those receiving benefits through traditional Medicare (as long as the overall Medicare benefit package provided by the plan is actuarially equivalent to coverage under traditional fee-for-service Medicare), States' liability for Medicare cost sharing charges for QMBs often exceeds what they normally would pay under fee-for-service Medicare; and (2) The claims submitted by MA Organizations to Medicaid claiming Medicare cost-sharing amounts for QMBs, often do not contain sufficient information on the service(s) provided to enable the State Medicaid Agency to determine Medicaid's liability. With this model, however, a State can meet its cost-sharing obligations for QMBs through the negotiation of an aggregate per capita payment to the MA Organization. Through negotiating an aggregate payment to cover QMBs' cost-sharing obligations,

States can limit their liability to what it would have been under traditional FFS Medicare. Doing so also can eliminate the substantial paperwork associated with plans' billing States, essentially on a fee-for-service basis, for the cost-sharing charges. However, States need to be careful in negotiating an appropriate methodology for determining the aggregate payment amount to ensure that the aggregate payment does not exceed what the State's obligation would be under traditional fee-for-service Medicare.

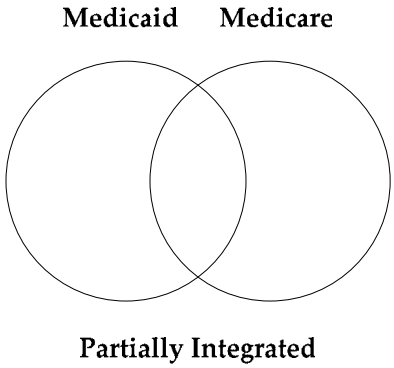
Finally, it is important to remember that States are only a financing mechanism under this model. If a plan does not cover Medicaid benefits in the same manner as the State Medicaid Agency, the Medicaid Agency does not have a contract with the MA Plan in which to exercise contractual oversight. Because there is no contract between the State and the MA Organization, States would not be able to exercise oversight of the MA Plan's provision of Medicaid-covered services. This might be attractive to States wanting largely to delegate oversight over the delivery of services to dual eligibles to Medicare. However, States wanting to monitor the quality, access, and cost of care provided to dual eligibles, for whom they are financially responsible, may prefer another model.

Pros and Cons of the Buy-In Wraparound

States employing the Buy-In Wraparound model would incur lower administrative costs, as the model minimizes paperwork and eliminates claims processing for the population enrolled. Thus, this model could be attractive to smaller States not wanting to administer a dual-eligible program themselves. On the other hand, the Buy-In Wraparound model leaves States with little leverage, oversight, or authority over the care provided to dual eligibles. This authority would reside with CMS-Medicare. Thus, States would have no mechanism to monitor quality, access, or cost of care. In addition, because MA Plans can design their own supplemental benefit packages and impose their own premium requirements for such benefits, States buying in to the supplemental benefit package to cover non-Medicare Medicaid benefits could end up paying for non-Medicaid services as well, thereby resulting in increased program costs to the State. For example, some MA supplemental packages may include home and community-based waiver services, which would not otherwise be available to dual eligibles under Medicaid. Thus, buying into the MA Plan's supplemental benefit package could result in a coverage expansion for Medicaid recipients, which, in turn, could result in increased costs to the State.

Model 2: Capitated Wraparound Model

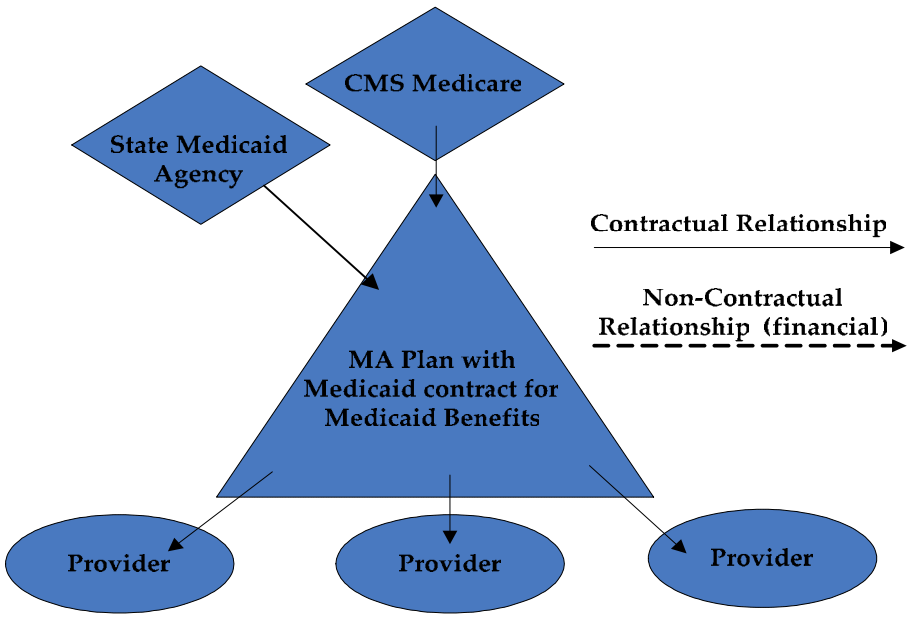
Figure 4. Partially Integrated Point on the Continuum



The "Capitated Wraparound Model" is a partially integrated model in which States negotiate a companion contract with an organization operating an MA Plan. The State Medicaid Agency would have a separate agreement with the organization, and would oversee the Medicaid contract. This model would be invisible to CMS Medicare, which would treat this organization like any other MA Organization. The Medicaid contract would address Medicaid benefits for beneficiaries with full Medicaid coverage, and could also include payments for beneficiaries eligible for Medicaid cost-sharing (e.g., QMBs). Because SLMB-only, QMB-only, QI, and QDWI beneficiaries are not eligible for full Medicaid benefits, individuals eligible for Medicare Part A and/or Part B premium and/or cost-sharing assistance under these eligibility groups would have to pay the Medicaid contract capitated rate themselves in order to receive the Medicaid-only benefits.

Graphically, the Capitated Wraparound Model can be depicted as follows:

Figure 5: Capitated Wraparound Model



Policy Considerations for the Capitated Wraparound Model

The Capitated Wraparound Model requires that the State exercise direct oversight over the services provided by the health organization pursuant to the contract between the State and the Plan. State Medicaid agencies also would need to coordinate with the MA Organization on enrollment and education. States could meet their Medicare cost-sharing obligations for QMBs through the negotiation of the capitation payment for wraparound services or by negotiating a separate premium payment (i.e., that is not tied to the capitation payment) to cover Medicare cost-sharing. As with the Buy-In Wraparound model, this would eliminate the need for reimbursing MA Plans for QMB cost-sharing charges on a fee-for-service basis.

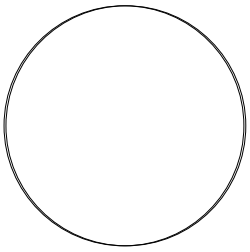
Because this model is invisible to Medicare, State Medicaid agencies are encouraged to consider modifying their contract requirements to mirror Medicare requirements as closely as possible, in order to reduce the burden of duplicate oversight on the organizations entering into contracts with both Medicare and Medicaid. The new Medicaid External Quality Review (EQR) requirements, for example, allow States to exempt an MCO or PIHP with an MA Plan in the same geographic area from the EQR requirements after two years of EQR compliance have passed.

Pros and Cons of the Capitated Wraparound Model

The Capitated Wraparound model (1) provides a mechanism for States to require managed care organizations to coordinate care between Medicare and Medicaid (note that any such requirement would need to be in the contract between the State and the health organization); (2) could eliminate fee-for-service billing, and the associated paperwork, associated with QMB cost-sharing charges; and (3) has the advantage of giving States some oversight of the Medicaid contract with the plan. However, while States may grant exemptions from some EQR requirements after two years of compliance, to be most effective, this model may require some modifications of States' current requirements for MCOs in order to align certain contractual requirements with Medicare requirements (e.g., quality of care measures). While States therefore may want to modify their requirements to match Medicare, this could have the effect of lowering State consumer protections that may be more vigorous for Medicaid recipients in that State than they are for Medicare. Finally, in reviewing contract and waiver requests from States seeking to implement this model, it will be important for CMS-Medicaid to consider how Medicare requirements governing MA Plans differ from current Medicaid managed care rules.

Model 3: Three-party Integrated Model

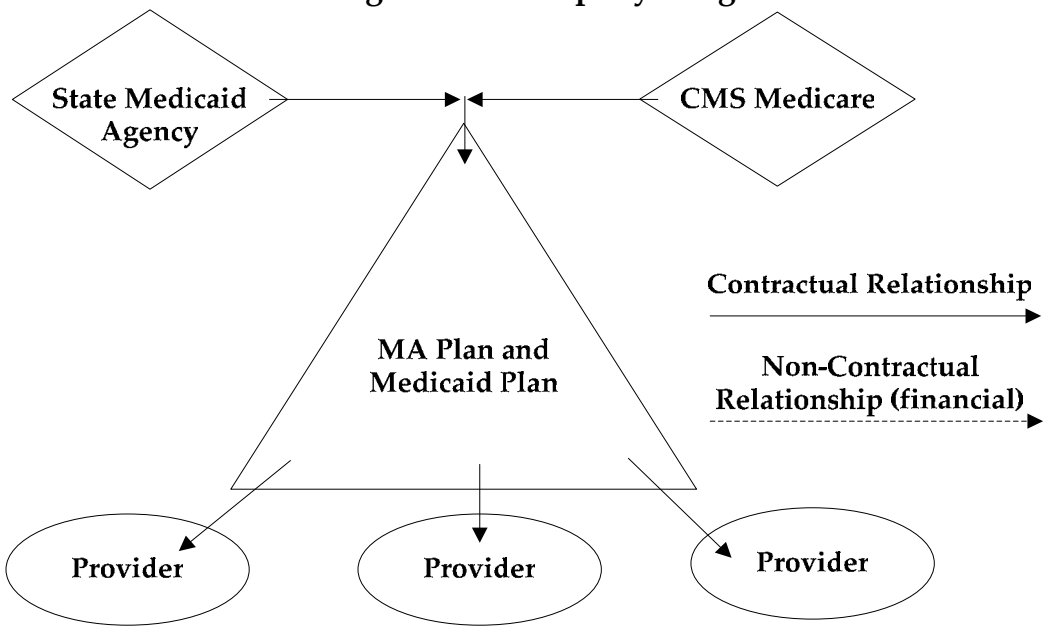
Figure 6. Fully Integrated Point on the Continuum



The "Three-party Integrated Model" is a fully integrated model in which the health organization, the State Medicaid Agency and CMS enter into a three-way contract, incorporating all relevant Medicare and Medicaid requirements. The organization would be required to coordinate both the Medicare and Medicaid acute and long-term care services, so that beneficiaries would have a fully integrated care delivery system. Medicare and Medicaid financing would be integrated through use of capitated payments to the organization. In addition, CMS-Medicare and the State Medicaid Agency would work together to coordinate enrollment procedures and dates, and a single set of member education materials for all members would be provided. If multiple entities were to receive a contract, CMS and the State Medicaid Agency would need to decide if the MA Organization or the State Medicaid Agency would be responsible for member education. In addition, the parties would need to determine beneficiaries' disenrollment rights. PACE (which operates under the authority of sections 1894 and 1934 of the Act and implementing Federal regulations at 42 CFR Part 460) and the dual-eligible demonstration in Massachusetts (operating under various waiver authorities provided under the Act) are two examples of programs that utilize this model.

Graphically, the Three-Party Integrated Model looks like this:

Figure 7: Three-party Integrated Model



Policy Considerations for the Three-Party Integrated Model

The Three-Party Integrated Model requires both CMS and the State Medicaid Agency

- To agree in advance to a uniform set of requirements to enable the health organization to provide a seamless Medicare/Medicaid product to dual eligible beneficiaries;
- To agree on whether additional administrative funds and/or services are required (such as the transportation and day-care center requirements in current PACE programs); and
- To coordinate review of marketing materials, contract oversight and on-site reviews.

Sections 1894 and 1934 of the Social Security Act allow PACE organizations to implement this model without the need for Medicare or Medicaid waivers. The dual-eligible demonstrations in Minnesota, Wisconsin, and Massachusetts operate as MA SNPS for 2006 but continue existing payment waivers under a section 402/222 Medicare payment waiver, and States may or may not need to request Medicaid waivers to implement this model. The State of Minnesota, for example, operates its current Three-Party Integrated Model program under section 1915(a)/1915(c) waiver authority, and Wisconsin operates under a section 1115 Medicaid waiver. Massachusetts, however, operates its dual eligible demonstration using authority under its Medicaid State plan.

Finally, as noted above, States can exempt a plan with an MA contract from the EQRO requirements after two years of compliance have passed.

Demonstration Considerations

- Medicare waivers: Under the current system, to fully integrate Medicare and Medicaid services, the health organization would need to work with the State within the State's procurement process. The State would need to request a Medicare Payment demonstration waiver, which would require budget neutrality under Medicare.

- Medicaid waivers: The State will need to consider whether to pursue a demonstration under the authority of section 1115, 1915(b) and/or 1915(c), or whether to develop its program within the confines of the flexibility afforded to it under its State plan. While 1115 demonstrations can afford States greater flexibility in tailoring eligibility requirements and benefits to different populations, 1115 demonstrations must embody a policy experiment, which would have to be evaluated; are granted for a time-limited period (usually 5 years); must be budget neutral; and have a lengthy application process, which must include an opportunity for public and stakeholder input and can take up to a year or more to complete.

- CMS, HHS, and OMB must approve all demonstrations.

Pros and Cons of the Three-Party Integrated Model

The Three-Party Integrated Model may offer the most potential to coordinate care between Medicare and Medicaid. It offers the possibility of a more seamless product, but also requires the negotiation of a prior agreement between CMS, the State and the health organization, which must navigate complex, often conflicting regulations and requirements on a variety of complex policy and procedural issues. This model also necessitates much closer coordination between the parties throughout the life of the contract. A Medicare waiver also was required in implementing these demonstrations. Obtaining such a waiver required CMS, HHS and OMB approval as well as Medicare budget neutrality; often entails lengthy negotiations between the State and CMS, and are time limited.

With the advent of the Medicare Modernization Act came the opportunity for a health plan to limit enrollment to those special needs individuals that are either dually eligible for Medicare and Medicaid, institutionalized or have chronic conditions. This opportunity called Special Needs Plans has also encouraged coordination of benefits between the health plan and the State. This coordination can either take the form of a Medicaid managed care contract with the health plan or coordination of benefits through a collaboration between the State and the health plan of what the duals are receiving through a Medicare managed care plan.

Because the statute limits the ability to offer Part D coverage to specified entities, fully integrated plans that wish to offer Part D benefits must qualify as Medicare Advantage plans, and participate in Medicare through Medicare Advantage contracts. Previously, fully integrated plans did not participate as MA organizations, though MA rules were incorporated as terms and conditions of the demonstrations. Variances from such requirements thus could be granted without waiver authority, and variances were granted with respect to non-payment related MA rules. Because entities wishing to offer Part D benefits are now MA organizations, and Medicare demonstration authority only permits waivers of payment-

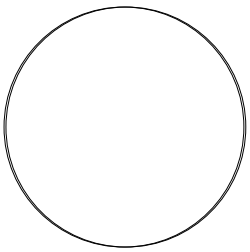
related rules, certain Variances that as were available in many of these demonstrations are no longer available.

Model 4: Plan Level Integrated Model

Figure 8. Fully Integrated Point on the Continuum

Medicare

Medicaid



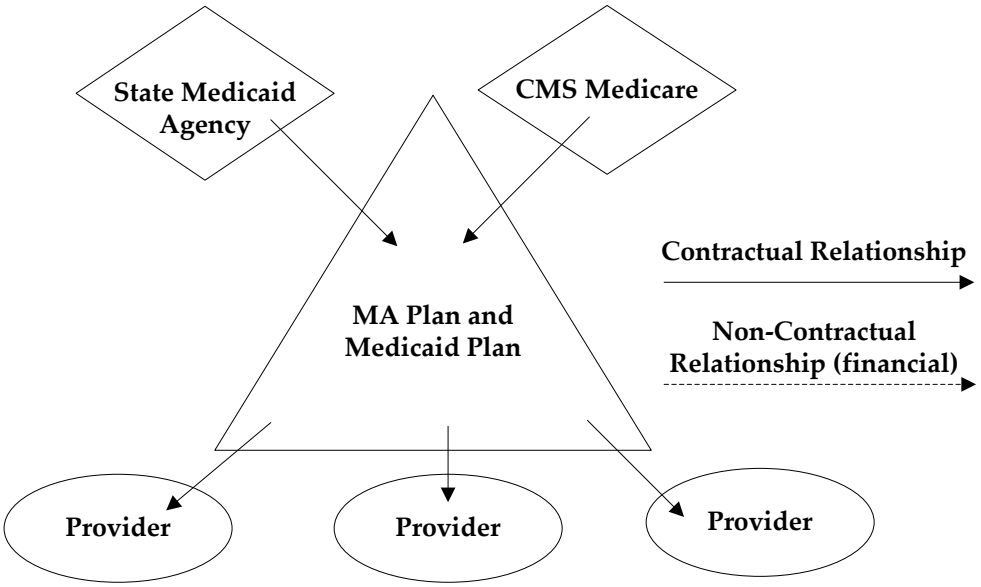
Integrated

The "Plan-Level Integrated Model" is a fully integrated model in which the health organization chooses to integrate separate Medicare and Medicaid contracts, negotiates the terms of its Medicare and Medicaid contracts separately with CMS and the State, and itself develops a single set of policies and procedures for the enrolled dual-eligible populations addressing both Medicare and Medicaid requirements. Although neither the State nor CMS initiates this model, both the State and CMS administers this model like any other non-integrated model. The health organization may find that this approach is faster to implement.

CMS works with State and health plans to develop uniform policies and procedures that facilitate the interoperability of MA SNP contracts with Medicare managed care contracts. Many features that have previously been available only through demonstration waivers and variances (described in Model 3) are now achieved by streamlining MA SNP policies and procedures with Medicaid program waiver or State plan arrangements.

Graphically, the Plan-Level Integrated Model can be depicted as follows:

Figure 9: Plan Level Integrated Model



Policy Considerations for the Plan-Level Integrated Model

The Plan-Level Integrated Model requires the health organization to work with both Medicare and Medicaid requirements; to determine a common set of policies, procedures, and processes that meet both requirements; and to negotiate two separate contracts with the State Medicaid Agency and Medicare that are consistent with both programs' requirements. In some cases, this could mean establishing higher standards than those required by Medicaid. Unlike the three-party integrated model, there is no need for CMS and the State Medicaid Agency to enter into a protracted negotiation period of waiver and contract requirements. The organization would operate like any other MA Plan with oversight by CMS-Medicare and like any other Medicaid managed care organization with oversight by the State Medicaid Agency. Thus, one of the primary advantages of this model is that an organization can implement it in a relatively short time frame.

On the other hand, the health organization needs to work with the State and CMS to coordinate enrollment dates, review of marketing materials and contract oversight. For example, coordination of enrollment dates between Medicare and Medicaid may be difficult. This is because, whereas enrollment in an MA Plan generally is controlled by the plan, enrollment in a Medicaid MCO generally is controlled by the State (or an enrollment broker hired by the State), so that the organization generally does not learn of a given beneficiary's enrollment in its Medicaid product until after the State has enrolled the individual in the plan. The lack of prior information regarding enrollment in its Medicaid product makes it even more difficult for the plan to coordinate Medicare and Medicaid enrollment dates. The more tightly the State Medicaid Agency controls enrollment and marketing, the greater this problem may be. Finally, an

organization implementing this model may request CMS and States to coordinate reviews of marketing materials and contract oversight activities.

The organization should determine and adopt the least common denominator of all Medicare and Medicaid requirements. For example, if CMS requires that all marketing materials contain certain items and the Medicaid State agency has different content requirements, then the organization should ensure that the joint materials contain all Medicare and Medicaid content so that the materials will meet both sets of requirements.

Pros and Cons of the Plan-Level Integrated Model

The Plan-Level Integrated model requires separate contracts between the health organization and CMS and between the organization and the State Medicaid Agency. This model can be implemented through current laws, regulations and guidance. The model entails less effort on the part of the State, whose administrative responsibilities would not change appreciably. The health organization may request combined policies and procedures that meet both Medicaid and Medicare standards, as well as coordinated oversight by CMS and the State Medicaid Agency. CMS and State Medicaid Agencies recognize the potential to enhance the options available to States and health plans in proceeding with the development of streamlined policies and procedures as were previously only possible in the types of health plans described in Model 3.

Specific Issue Considerations

In the descriptions above, we attempted to outline the differences between the models and the various contractual relationships that embody them. Table 3 summarizes the differences in contractual relationships associated with each model. Table 4 compares the operational differences between the models, which also should be considered. Following these tables is a point-by-point analysis of the different issue considerations that arise in the context of each model.

Table 3: Comparison of Contractual Relationships

	Model			
Issue	**Model 1: Buy-in Wraparound Model**	**Model 2: Capitated Wraparound Model**	**Model 3: Three-party Integrated Model**	**Model 4: Plan-Level Integrated Model**
Contract with State Medicaid Agency allows for State oversight		X	X	X
Contract with CMS Medicare allows for Medicare oversight	X	X	X	X
Single contract encompasses both Medicare and Medicaid benefits	X		X	
Integrated model is implemented without any additional changes to the Medicaid managed care program/contract				X
Integrated model is implemented without any additional changes to the Medicare managed care program/contract		X		X

Table 4: Comparison of Model Issue Considerations

	Model			
Issue	**Model 1: Buy-in Wraparound Model**	**Model 2: Capitated Wraparound Model**	**Model 3: Three-party Integrated Model**	**Model 4: Plan Integrated Model**
A. Enrollment materials are reviewed by both Medicare and Medicaid staff		X	X	X
B. Cost-sharing - Supplemental Medicare Premium option in the Medicaid State plan must be marked	X			
C. Benefits - The State Medicaid Agency could cover all Medicaid benefits including HCBS services only for those eligible for HCBS		X	X	X
D. Organizational Issues - Organizations would be required to meet both Medicare and Medicaid requirements.		X	X	X

Issue	Model			
	Model 1: Buy-in Wraparound Model	Model 2: Capitated Wraparound Model	Model 3: Three-party Integrated Model	Model 4: Plan Integrated Model
E. Marketing - Medicare and Medicaid would separately review marketing materials subjecting the health organization to two separate reviews.		X		X
F. Contracting and Procurement – CMS recommends against restricting plan participation through Competitive procurement		X	X	
G. Service Area is chosen by Medicaid State Agency		X	X	
H. State information systems changes may be needed		X	X	
I. Ratesetting - Medicaid capitated rate would be actuarially sound and set under Medicaid regulations.		X	X	X
J. Funding streams and reporting must separately account for Medicare and Medicaid funds and services rendered.		X	Depends on final program design	X
K. Medicaid regulation of organization would require the plan to be State licensed, meet statutory exceptions, or obtain demonstration authority.		X	Depends on final program design	X
L. Member appeals processes have a single integrated appeal process for Medicare and Medicaid.	X		Depends on final program design	
M. Quality oversight would include separate Medicare and Medicaid requirements that are not tailored to reduce duplication with Medicare.		Recommend State to tailor requirements		X
N. Implementation requires compliance with non-payment related MA rules if Part D is offered by plans.			X	

A. Enrollment Considerations

Considerations applicable to all models

In thinking about the enrollment considerations for any of the models, several general points should be kept in mind. Preliminarily, the Balanced Budget Act of 1997 granted States the authority under their State plan to require many Medicaid recipients to enroll in a managed care product. However, Congress specifically excluded the mandatory enrollment of dual eligibles in managed care under a State plan.

Consequently, States wishing to implement model 2, 3 or 4 and to mandate the enrollment of dual eligible recipients into a Medicaid managed care product must receive a waiver, under either section 1915(b) or 1115 of the Act, of the freedom of choice requirements found in section 1902(a)(23).

A State operating under a waiver of duals' freedom of choice could assign dual eligibles who do not choose a plan into the MA Plan which is attempting to coordinate benefits. Obtaining such a waiver, however, would only permit States to require dual eligibles to receive Medicaid-only services through a managed care product. While an organization may contact duals who are enrolled in the organization's Medicaid product and encourage them also to join the organization's Medicare product, neither a 1915(b) nor 1115 waiver of Medicaid's freedom of choice provisions would enable States to require duals to receive Medicare-covered services through an MA Plan.[2] If the State offers more than one Medicaid managed care product, a State with such a waiver could assign dual eligibles who do not make a choice into the managed care organization which is attempting to coordinate benefits.

As noted earlier, because SLMB-only, QMB-only, QI, and QDWI beneficiaries are not eligible for full Medicaid benefits, any such beneficiaries enrolled in an MA Organization must themselves pay the capitated rate associated with any supplemental package offered by the MA Plan which covers Medicaid benefits, in order to receive such supplemental Medicaid benefits. However, under section 231 of the MMA and implementing Federal regulations, SNPs may limit enrollment to full benefit dual eligibles or other "special needs" individuals. Before regulations were issued, SNPs were limited by statute to enrolling all dual eligibles interested in joining the plan, including those eligible as QMB-only, SLMB-only, QI or QDWI, whose Medicaid benefits are limited to assistance with Medicare premiums and/or cost sharing (see Chart 1 for categories of dual eligibles). The new rules allow SNPs to exclude from participation dual-eligible beneficiaries who are not eligible for full Medicaid benefits and who would have to pay the Medicaid capitated rate in order to receive any Medicaid-only benefits available through the SNP. Thus, SNPs now may design a product only for individuals fully eligible for both Medicare and Medicaid.

Model 1: Buy-In Wraparound Model

Under Model 1, there would be no need to coordinate enrollment in a Medicaid managed care plan with enrollment in the MA Plan, as the enrollee would only be a member of the MA Plan. Member education and enrollment would be done entirely through Medicare; enrollees would only be subject to Medicare Advantage enrollment and disenrollment requirements; and only CMS-Medicare would exercise oversight of the plan. To the extent that the MA Plan did not cover a Medicaid service, either at all or in a particular instance, Medicaid would continue to provide wraparound coverage, and beneficiaries would retain Medicaid hearing and appeal rights of adverse decisions relating to such coverage. Because there

[2] While CMS has had a policy since the mid-1990s of not approving such waivers, CMS has approved in the past of waivers under which coverage of Medicare cost-sharing amounts is conditioned upon receiving services through a managed care product. These few existing waivers were "grandfathered" when CMS adopted a policy of no longer approving of such arrangements. We note that even in such States, if they are not enrolled in an MA plan or other managed care plan for Medicare, dual eligibles retain their rights as Medicare beneficiaries to get services from any Medicare provider and receive the reimbursement that Medicare provides. They would only go without the medical assistance that would be provided to cover Medicare cost-sharing if services were received in network.

is no need for an enrollment broker or other types of Medicaid administrative activities, Medicaid administrative costs may be less for this model.

However, the State Medicaid Agency would not exercise oversight of the MA Plan itself. This would have the advantage of (1) eliminating many of the complications inherent in a system of dual oversight by both CMS-Medicare and the State Medicaid Agency and (2) lowering Medicaid administration costs. The lack of Medicaid oversight of the plan, however, could be problematic if the plan does not correctly implement the supplemental benefits or correctly educate beneficiaries.

Model 2: Capitated Wraparound Model

Under this model, CMS-Medicare would not be required to take the Medicaid enrollment process into consideration. Rather, the Medicaid Agency would need to work with the MA Organization(s) in order to coordinate plan enrollment dates. In addition, some of the MA Organization's members may be eligible for Medicaid as QMB-only, SLMB-only, QI or QDWI; because these dual eligibles are not eligible for full Medicaid benefits, they may not be enrolled under the Medicaid contract (although they could receive the Medicaid-only services if they paid the Medicaid capitation rate themselves.)

Model 3: Three-Party Integrated Model

Under the Three-Party Integrated Model, the Medicaid State Agency, CMS and the health organization would agree to a single set of contract provisions incorporating all relevant Medicare and Medicaid requirements. The Medicare and Medicaid enrollment processes would be merged and enrollment dates coordinated to ensure that the beneficiary is enrolled simultaneously in the integrated product. The State, CMS, and the health organization would all educate beneficiaries regarding beneficiary choice and the integrated Medicare/Medicaid health care product, and the organization would have a single set of education materials for all members. Further, the organization would be required to coordinate the delivery of both Medicare and Medicaid services. If multiple entities were to receive a contract, CMS and the State Medicaid Agency would need to decide if the organization (as is the case under Medicare) or the State Medicaid Agency (as is the case under Medicaid) would be responsible for member education. In addition, the parties would need to determine beneficiaries' disenrollment rights. For example, under PACE and most current dual eligible demonstrations, beneficiaries have the right to disenroll at any time.

The State would need to obtain a waiver to require Medicaid dual eligible beneficiaries to enroll in a plan for purposes of receiving Medicaid benefits, since, without a Medicaid waiver, beneficiaries must enroll voluntarily. In addition, any accommodations made by Medicare or Medicaid to assist in streamlining the administration of the plan – e.g., with respect to enrollment, marketing and oversight – would need to be articulated in an approved waiver. While States may through a waiver of freedom of choice limit the number of plans awarded a Medicaid contract, CMS recommends that the State instead cooperatively contract with any qualified and willing organization and seek a waiver requiring dual eligible beneficiaries enrolled in an MA Plan to enroll in the same entity's Medicaid product. Excluding plans in which dual eligible beneficiaries may be enrolled for Medicare would mean that these enrollees would be unable to take advantage of the integrated care offered under participating plans. (*The point is that duals in a MA plan that isn't awarded a contract won't have the opportunity to be served in an integrated setting unless they choose to change plans and enroll in an MA plan that does have a contract with the State*.) Note that some

States require mandatory enrollment into Medicaid managed care through a waiver and then allows beneficiaries a voluntary choice into the dual eligible integrated plan.

In implementing this model, the State and CMS would need to determine whether enrollment in the plan would be limited to individuals who are eligible for full benefits under both Medicare and Medicaid, or whether other individuals not eligible for full Medicare and/or Medicaid benefits may also be enrolled. Under PACE, for example, a Medicare beneficiary eligible for Part A or Part B only may enroll in a PACE organization (the beneficiary would then be liable for the portion of the Medicare premium not paid by CMS.) MA Plans, however, require that beneficiaries be enrolled in both Medicare Parts A and B in order to enroll in the plan. Further, almost all MA Organizations will have at least some enrollees who are not eligible for Medicaid, and almost all Medicaid managed care plans will have at least some enrollees not eligible for Medicare.

If individuals other than those with full Medicaid benefits and Medicare coverage are permitted to enroll in the integrated plan, the parties will need to determine the extent to which all enrollees will enjoy the same benefits and protections, regardless of their eligibility for Medicaid and/or Medicare; what the State's responsibilities for enrollees not eligible for Medicaid will be; and what CMS-Medicare's responsibilities for enrollees not eligible for or enrolled in Medicare Parts A and/or B will be. (It is assumed that neither the State nor CMS will have a role if the beneficiary is neither Medicare nor Medicaid eligible.) As a condition of approving managed care demonstrations, CMS typically has required, as a matter of policy, that all enrollees in a given plan be afforded equal protection and treatment. Under the PACE program, which currently operates as a Medicaid State Plan option, for example, single coverage Medicare eligibles receive similar protections (in terms of comprehensiveness of benefits) as dual eligibles. This has historically created a disincentive for some plans to participate in demonstrations that employ an integrated plan model, as they would have been required to provide protections to some enrollees beyond what is strictly required by the program for which the enrollees were eligible (i.e., Medicare-only enrollees would have been entitled to receive Medicaid services, and vice versa). The new rules, which will permit SNPs to limit enrollment to individuals with full Medicaid and Medicare coverage, may eliminate a critical barrier to health organizations' interest in developing an integrated plan.

Model 4: Plan-Level Integrated Model

In the Plan-Level Integrated Model, the MA Organization chooses itself to integrate service delivery under separate Medicare and Medicaid contracts. Thus, the MA Organization would need to meet all Medicare and Medicaid requirements for education and enrollment. Without the active participation of CMS-Medicare and the State Medicaid Agency, coordination of enrollment dates between Medicare and Medicaid will be difficult, especially if the State Medicaid Agency controls enrollment and marketing tightly and/or enrollment in competing Medicaid managed care plans is handled by an enrollment broker. One strategy that an MA Plan could employ would be to contact those dual eligibles enrolled in its Medicaid product to encourage them to enroll in its Medicare product as well.

B. Cost-Sharing Considerations

Considerations applicable to all models

State payment of Medicare cost sharing is mandatory for QMBs (including those enrolled in an MA Plan), regardless of whether the State has elected in its State plan to cover premiums for QMBs enrolled in MA Plans. Further, Medicaid must pay the full amount of the Medicare cost sharing incurred by a QMB, unless a methodology requiring a lesser amount is specified in the Medicaid State plan. For example, States may limit payment of Medicare cost-sharing for QMBs enrolled in Medicare managed care as well as those enrolled in fee-for-service Medicaid based on the Medicaid payment rate specified in the Medicaid State plan for the same service.

States have indicated that payment of QMB cost sharing under Medicare managed care is problematic when they do not receive a bill from a Medicare managed care provider with sufficient information on the service(s) provided. In addition, Medicare plans are free to impose cost-sharing obligations on their members that are different from those employed in traditional Medicare, as long as the overall Medicare benefit package they provide is actuarially equivalent to coverage under traditional fee-for-service Medicare. Some States have objected to paying cost sharing that exceeds what they would pay under fee-for-service Medicare.

Under all models, States can meet their cost-sharing obligations for QMBs through the negotiation of an aggregate *per capita* payment to an MA Plan to cover Medicare cost-sharing charges incurred by QMBs enrolled in the Plan. Doing so could avoid problems encountered when the MA Plan or provider does not or is unable to identify the services provided with sufficient specificity for the State Medicaid Agency to determine what Medicaid's cost sharing liability should be. States choosing to negotiate an aggregate payment to MA Plans may want to negotiate separate payments to cover Medicare cost sharing versus wraparound Medicaid services. As more QMBs enroll in Medicare managed care, States may find that this is the most attractive method for payment of such cost sharing.

If the MA Plan or SNP does not limit enrollment to full benefit dual eligibles, but opens enrollment to all dual eligibles, including those eligible as QMB-only, SLMB-only, QI and QDWI, other cost sharing considerations must be taken into account. First, SLMB-only's, QIs and QDWIs would be required to pay their own cost-sharing charges. Second, for QMB-only's, States may need to separate payment of any premium covering Medicaid's liability for Medicare cost sharing charges from any premium associated with Medicaid wraparound services provided through a supplemental package offered by the plan. This would have to be done in States that have not opted to cover the premium for QMBs enrolled in an MA Plan.

Model 1: Buy-In Wraparound Model

While States can opt to cover the premium for QMBs to enroll in an MA Plan, they are not obligated to do so, and in no event is FFP (Federal Financial Participation) available to cover the premiums for other Medicaid recipients who receive medical assistance only for their Medicare Part B premiums (i.e., SLMB-only's, QIs and QDWIs) . Thus, these individuals would be required to pay the premiums for both the

Medicare product as well as any Medicaid wraparound services provided by the MA Plan. This would render enrollment less attractive to such beneficiaries, who may not be able to afford to pay the premium.

C. Determination of Plan Benefits

Considerations Applicable to Multiple Models

Models 2 and 3 would provide a contracting vehicle for States to require MA Organizations to coordinate care between Medicare and Medicaid. The sharing of any data or clinical information needed by the MA Plan to coordinate beneficiaries' care and/or by the State to exercise appropriate oversight would need to be spelled out in the contract. Also in Models 2 and 3, for dual-eligible beneficiaries enrolled in a Medicaid Home and Community Based Services (HCBS) waiver, the State and the health organization would need to ensure that only individuals enrolled in the HCBS waiver received these benefits. The State could ensure that a separate capitated rate and benefit is created only for individuals eligible for HCBS under these models.

Model 1: Buy-In Wraparound Model

Under model 1, dual eligibles with full Medicaid benefits generally would receive all Medicaid services through the MA Plan, which would cover Medicaid-only services under a supplemental benefit package, with a premium reimbursed by Medicaid. Thus, the dual eligible's entire benefit package would become capitated MA benefits subject to the MA rate setting regulations and statutes. The MA Plan would reimburse providers for both Medicare and Medicaid services provided to plan enrollees, and also would be responsible for member education, utilization review, provider recruitment, etc.

All Medicaid full benefit dual-eligible beneficiaries generally would receive all Medicaid benefits under the MA supplemental benefits package. (To the extent that the plan did not cover a Medicaid service, either at all or in a particular instance, Medicaid would continue to provide wraparound coverage, and beneficiaries would retain Medicaid hearing and appeal rights of adverse decisions relating to such coverage.) An exception to this may be home and community based services (HCBS) for Medicaid beneficiaries enrolled in a 1915(c) HCBS program. Because not all Medicaid beneficiaries are eligible for HCBS, an MA Plan might not include these services in its supplemental package. If the Plan did decide to include HCBS services in the supplemental benefit package, Medicaid State agencies would be unlikely to purchase the additional HCBS services for beneficiaries not eligible for those services, as no FFP in such expenditures would be available.

Model 2: Capitated Wraparound Model

All wraparound Medicaid services (i.e., services covered by Medicaid but not Medicare) would be provided under the contract negotiated between the State Medicaid Agency and the health organization, which also could serve as a vehicle for the State to require the organization to coordinate Medicare and Medicaid services. States would need to decide whether to reimburse the organization for Medicaid wraparound services on a capitated or fee-for-service basis. If the State were not operating under an 1115 demonstration waiver, any Medicaid benefits not covered under the Medicaid contract with the

organization would need to be provided on a fee-for-service basis; this would complicate matters for beneficiaries needing such services.

Model 3: Three-Party Integrated Model

All Medicaid and Medicare benefits would be covered under the benefit package provided by the plan and subject to the three-way contract between the State Medicaid Agency, CMS and the health organization. This contract also could serve as vehicle for the State and CMS to require the organization to coordinate care covered by Medicare and Medicaid. In addition, the State Medicaid Agency and CMS would need to determine whether the plan would be required to provide any additional services or to engage in any additional administrative activities. For example, PACE requires plans to maintain a day care center and transport beneficiaries to that center to receive care.

Both CMS-Medicare and the State Medicaid Agency would make a capitated payment to the MA Plan. As is the case in PACE, Medicare and Medicaid financing may be integrated in a single funding stream, with the identity of the original funding source for any given payment lost. Note that, in both PACE and the current dual-eligible demonstrations, a frailty adjuster is applied to the capitated payment. Unless a payment waiver is obtained or CMS changes its payment policies, no frailty adjustor is anticipated for SNPs or MA Plans serving dual eligibles or the institutionalized. If the payments are capitated, providers would be paid by the health organization.

Model 4: Plan-Level Integrated Model

In the Plan-Level Integrated Model, the Medicaid benefit package would be governed by the State's Medicaid managed care program and the Medicare benefit package (and rate) would be determined through the MA bid process. The organization could operate as a Medicaid fee-for-service provider through a non-risk contract, if permitted by the State. If not (some States require that the FFS providers be the licensed practitioners and do not allow a non-risk MCO to contract with the State), then the plan would have to operate as a capitated Medicaid MCO or PIHP and pay claims and perform other administrative activities (e.g., utilization management and credentialing) required under the State's Medicaid managed care program.

D. Organizational Issues

Considerations applicable to all models

Regardless of the model chosen, the new rules enabling SNPs to limit enrollment to dual eligibles with full Medicaid benefits may create an incentive for Medicaid MCOs providing Medicaid benefits to the institutionalized and dual eligibles also to become an MA Organization/SNP, thereby enabling them to provide Medicare benefits to these individuals as well.[3] CMS and States could make special overtures to Medicaid MCOs to become MA SNPs in order to provide Medicare services to dual eligibles. Medicaid

[3] As of June 30, 2003, there were 120 Medicaid-only MCOs enrolling 6,848,585 Medicaid beneficiaries, and approximately 60 State Medicaid managed care programs that cover either aged or disabled individuals and do not specifically exclude beneficiaries who are eligible for Medicare. This is in addition to the 32 existing PACE programs.

MCOs that do so may be able to streamline administrative activities and would be well poised to transition Medicaid recipients enrolled in their Medicaid managed care product into their integrated Medicaid-Medicare product when they become eligible for Medicare.

Similarly, MA Organizations (including regional PPOs) may have an incentive, and could be encouraged, to participate in any of the models, by offering a Medicaid supplemental package or otherwise negotiating a contract to cover Medicaid services for dual eligibles. Large national or regional MA Organizations that choose to do so also might be able to streamline administrative activities. However, while well acquainted with serving Medicare beneficiaries, MA Organizations may need additional help in understanding the unique characteristics and needs of dual eligibles.

Finally, note that both for-profit and non-profit organizations can operate under each of the models, although PACE (which falls under Model 3) permanent provider status is limited to non-profit organizations. For-profit organizations can operate as a PACE demonstrations.

Model 1: Buy-In Wraparound Model

Since the State Medicaid Agency would exercise no control over the MA Plan, this model offers some advantages to the MA Organization as well as CMS-Medicare in simplifying the coordination and oversight of services provided to dual eligibles. From Medicaid's perspective, it also reduces administrative costs. However, under this model the State Medicaid Agency has no ability to impose additional requirements or otherwise to monitor the operations of the MA Plan's provision of Medicaid services.

E. Marketing

Model 1: Buy-In Wraparound Model

Under this model, the MA Organization will be subject only to MA requirements. CMS-Medicare would approve all marketing materials, with no oversight exercised by the State Medicaid Agency.

Model 2: Capitated Wraparound Model

Although the health organization may choose to develop only one set of marketing materials for both products, this model requires that both CMS and the State Medicaid Agency review marketing materials for compliance with their respective programs. Communication between the CMS Regional Office reviewing for compliance with Medicare requirements and the State Medicaid Agency reviewing for compliance with Medicaid requirements would be helpful in preventing conflicting reviews. If two sets of marketing materials were developed, CMS-Medicare would review MA marketing materials and the State Medicaid Agency would review Medicaid marketing materials.

Model 3: Three-Party Integrated Model

Under the Three-Party Integrated Model, a single set of marketing materials for both Medicaid and Medicare would be created, and review of marketing materials would be coordinated between the State

Medicaid Agency and CMS Medicare staff. A coordinated review should decrease approval time and mitigate conflicts between CMS and State Medicaid Agency requirements.

Model 4: Plan-Level Integrated Model

As in Model 2, the health organization may choose to develop only one set of marketing materials for both products. However, this model also requires that both CMS and the State Medicaid Agency review marketing materials for compliance with their respective programs. Communication between the CMS Regional Office reviewing for Medicare requirements and the State Medicaid Agency reviewing for Medicaid requirements would be helpful in preventing conflicting reviews.

F. Contracting and Procurement

Note: this section makes distinctions between open procurement and competitive procurement. CMS requires States to follow their own State procurement guidelines, subject to Federal requirements (45 CFR 92.36(b))

Competitive procurement occurs when a State releases a request for proposal (RFP) or a request for information (RFI) considers all willing and qualified responders for contracting, but limits the number of contractors.

Open procurement occurs when the State offers contracts/program agreements to all willing providers meeting technical requirements of the program.

Sole source contracting occurs when the State determines that only a single entity is quailed for the contract in question, or otherwise justifies an exception to the requirement for competitive procurement where the number of contractors is limited.

Model 1: Buy-In Wraparound Model

MA Organizations would follow MA contracting, access, credentialing, and provider requirements. No Medicaid contract would exist.

Model 2: Capitated Wraparound Model

In establishing provider networks, CMS would address Medicare provider network needs focusing on the Medicare benefits and requirements and the State Medicaid Agency would address Medicaid provider network needs focusing on Medicaid benefits and requirements. The simplest way for State Medicaid Agencies to implement this model from a contracting and procurement standpoint would be for the State Medicaid Agency to use open cooperative procurement to contract with all MA Organizations in the State which were willing to sign a contract for Medicaid wraparound services. The State could then seek a Medicaid waiver requiring dual eligibles enrolled in an MA Plan for Medicare services also to enroll in the same plan for Medicaid services. If the beneficiary has not chosen to enroll in an MA Plan in Medicare, the Medicaid agency could auto-assign the beneficiary to a plan for all Medicaid wraparound services.

In States with more MA Organizations in the State than needed to provide Medicaid wraparound services to dual eligibles, the State could obtain a freedom of choice waiver to use competitive procurement to limit the number of MA Plans with which it contracts to provide the Medicaid services. However, because dual eligibles enrolled in the excluded MA Plans would not enjoy the benefits of integrated care, CMS does not recommend limiting the number of contracts through competitive procurement. Instead, CMS recommends that the State cooperatively contract with any qualified and willing organization and seek a waiver requiring dual eligible beneficiaries enrolled in an MA Plan to enroll in the same entity's Medicaid product.

Model 3: Three-Party Integrated Model

CMS and the State Medicaid Agency will need to determine the provider network needs of both programs, the number of entities for which a contract will be granted and how the procurement is to be accomplished. In PACE, the State is permitted to select the provider using its State procurement guidelines and then to submit the application to CMS on the provider's behalf. As with Model 2, however, we recommend that the State not limit the number of organizations awarded a Medicaid contract, but instead offer contracts to all interested and qualified organizations in the State and apply for a Medicaid waiver requiring dual eligibles already enrolled in an MA Plan to also enroll in the organization's Medicaid product. If competitive procurement is used and the number of MA Plans permitted to enter into the three-way agreement is limited, duals enrolled in an excluded MA Plan will not be afforded the benefits of integrated care.

Model 4: Plan-Level Integrated Model

Under this model, the organization would obtain Medicare and Medicaid contracts using the contracting and procurement vehicles that the State and CMS already employ. This model would not affect contracting and procurement, as CMS would address Medicare provider network needs focusing on the Medicare benefits and the State Medicaid Agency would address Medicaid provider network needs focusing on Medicaid benefits.

G. Service Area

Model 1: Buy-In Wraparound Model

MA rules would govern the service area.

Model 2: Capitated Wraparound Model

MA rules would govern the service area of the Medicare product. Thus, the scope and breadth of any particular MA Plan's service area will depend upon what CMS approves, although we anticipate that every State will have at least one MA Organization statewide through the new MA regional PPO program. For Medicaid, the scope and breadth of a capitated wraparound system would depend on the State's success in negotiating wraparound contracts with the MA Organizations operating in the State, and the scope and breadth of each MA Organization's service area. There may be areas with multiple

MA Organizations with which the State may successfully negotiate a companion Medicaid capitated contract, and regions for which the State is unable to negotiate any companion Medicaid contracts.

Model 3: Three-Party Integrated Model

The service area would be determined through the joint negotiations between CMS, the State Medicaid Agency and the organization. For example, the State and CMS could agree to have a regional program with multiple entities or a single statewide entity contract, provided that there are organizations interested in entering into the required contract.

Model 4: Plan-Level Integrated Model

Medicaid rules would govern the service area requirements for the Medicaid contract and Medicare rules would govern the requirements for the Medicare contract. Thus, the scope of the integrated program will depend upon the organization's ability to negotiate contracts with CMS and the State Medicaid Agency and to establish the provider networks needed to implement this model.

H. Information Systems Considerations

For all models, the organization would need information systems necessary for all quality, enrollment, and claims payment requirements in Medicare. For Models 2, 3, and 4, the organization would need such information to satisfy Medicaid requirements as well.

Model 1: Buy-In Wraparound Model

States would have no information systems changes and would process payments under this model like any Health Insurance Premium Payment (HIPP) or Medicare buy-in premium.

Model 2: Capitated Wraparound Model

With respect to information systems and payment systems, the State would need to establish the health organization as Medicaid managed care plan within the State information system if the organization did not already have a Medicaid contract. Depending upon the extent of the changes needed an Automated Data Processing (ADP) Request, requiring CMS approval, might be necessary. In addition, the entity would need information systems necessary for all quality, enrollment, and claims payment requirements in Medicare and Medicaid.

Model 3: Three-Party Integrated Model

The same considerations apply as in Model 2.

Model 4: Plan-Level Integrated Model

The State would have no additional information system changes other than what would be required for its typical Medicaid managed care contracting organizations.

I. Rate Setting

There are two separate rates which States may wish to negotiate with contracting plans: (1) a rate to cover Medicaid-covered services for individuals eligible for full Medicaid benefits, discussed in the context of each model below; and (2) a rate to cover Medicare cost-sharing charges for QMBs. For QMB-Plus individuals (i.e., individuals eligible for full Medicaid benefits as well as for Medicare cost-sharing assistance), the State could negotiate a single rate covering both items, or two separate rates.

For Medicare Advantage, MA Organizations will need to follow the new MA bid process for each plan. The new process compares the MA Plan proposal to a statutorily-determined "benchmark" amount. If the bid for providing Medicare services covered under Parts A and B is above the benchmark amount, this must be charged in a premium. If it is below, 75% of this amount must be provided in rebates to enrollees or additional benefits, with the remaining 25% remaining in the Medicare Trust Funds.

Model 1: Buy-In Wraparound Model

Rates for MA Organizations, including the supplemental Medicaid benefits, will be set using MA rules.

Model 2: Capitated Wraparound Model

Medicare rates would be set according to MA guidelines. Capitated Medicaid rates must be actuarially sound according to Medicaid requirements. If the Medicaid rates negotiated are non-risk, then the organization would be paid an administrative payment based on the costs saved by the State in not processing claims, and would be reimbursed the equivalent of what would be paid under the Medicaid State plan fee-for-service fee schedules for the services provided.

Model 3: Three-Party Integrated Model

Rates would be set as in Model 2, unless Medicare grants the State a variance for payment under a Medicare waiver. If that were to happen, the terms of that variance would be negotiated between the State and CMS, which could result in a frailty adjustor being applied to the Medicare payment.

Model 4: Plan-Level Integrated Model

Rates would be set as in Model 2, consistent with Medicare and Medicaid requirements.

J. Funding Streams and Reporting Requirements

In all models, the health organization would be accountable for tracking funding sources separately, and distinguishing Medicare and Medicaid from other public and private funding sources. The organization also would be responsible, in all models, for reporting services rendered to CMS in a manner that would facilitate future Medicare rate setting and, in Models 2, 3, and 4, for reporting funding sources to the State Medicaid Agency in a manner that would facilitate future Medicaid rate setting.

Model 1: Buy-In Wraparound Model

The State would process payments under this model like any Health Insurance Premium Payment (HIPP) or Medicare buy-in premium.

Model 2: Capitated Wraparound Model

Under this model, the health organization would need to separately track Medicare and Medicaid funds and services for each enrollee. The organization also would need to separately fulfill Medicaid and Medicare reporting requirements, such as providing encounter data and other financial reports. To facilitate compliance on the organization's part, it is recommended that the State Medicaid Agency tailor the Medicaid contract provisions to meet both Medicare and Medicaid requirements, rather than imposing separate Medicaid requirements on the plans. The contracts between the organization and the State also would need to address any data sharing between the Medicare and Medicaid products required to integrate clinical care.

Model 3: Three-Party Integrated Model

Depending upon the terms of the contract negotiated, the health organization may need to separately track Medicare and Medicaid funds and services for each enrollee. PACE does not require such tracking. Depending upon the negotiated terms and conditions of an 1115 demonstration such reporting may be required. Otherwise, the organization would need to comply with joint reporting requirements agreed to by CMS-Medicare and the State Medicaid Agency.

Model 4: Plan-Level Integrated Model

As under Model 2, the health organization would need to separately track Medicare and Medicaid funds and report services rendered back to each funding source. The organization would need to comply with both MA and Medicaid reporting requirements.

K. Regulation of the Entities

Model 1: Buy-In Wraparound Model

The organization would need to comply with all Medicare Advantage regulatory requirements.

Model 2: Capitated Wraparound Model

In the capitated wraparound scenario, the entity would need to meet MA Plan requirements as well as the Medicaid licensure and solvency requirements If the State contracts with a large group under Medicaid and the group is not licensed, it is uncertain how the State would regulate the entity with respect to financial solvency, access to care, and quality of care, as well as other administrative and organizational requirements. Medicare allows provider-sponsored organizations to receive a waiver of State licensure.

Model 3: Three-Party Integrated Model

PACE programs under this model would need to meet PACE-specific requirements. For example, PACE programs under the permanent PACE status must be non-profit. States may require PACE programs to be State-licensed as a risk-bearing entity. There are no federal requirements that PACE programs be licensed insurance companies.

Under demonstrations, the exact regulation of the health organization would depend upon the negotiations between CMS, the State and the organization. It is assumed that (1) the organization would meet non-payment-related MA Plan requirements, and (2) Medicaid would require the organization to be State-licensed or meet alternative requirements or exceptions.

Model 4: Plan-Level Integrated Model

The organization would need to meet MA Plan requirements and State Medicaid managed care requirements, including being State-licensed or meeting alternative solvency standards, or meeting one of the four statutory exceptions to these requirements.

L. Member Appeals Process

Medicare and Medicaid have different regulations governing appeals and grievance procedures for managed care organizations (MCOs). The Medicaid regulations are found in 42 CFR Part 438 Subpart F; the corresponding Medicare regulations are found in 42 CFR Part 422 Subpart M. MCOs paid on a capitated basis for both Medicare and Medicaid will have to contend with conflicting requirements in the Medicare and Medicaid regulations for appeals and grievances.

The following table presents several key points of divergence between the Medicare and Medicaid appeals and grievance regulations.

Table 5: Medicare and Medicaid Appeals Comparison

Appeal Time Frames (all types of appeals)	Medicaid	Medicare
Timeframe within which a member must request reconsideration (appeal)	Determined by State, but not less than 20 or more than 90 days from Notice of Action (NOA). ***42 CFR 438.402(b)(2)***	Within 60 days of a notice of an "organizational determination" (the Medicare term for a NOA). ***42 CFR 422.582 (b)***
Plan must respond to Request For Reconsideration (RFR)	As quickly as the enrollee's health condition requires, but no more than 45 days from the time the plan receives the request for appeal, with a potential 14-day extension unless expedited resolution is granted, in which case a decision must be made within 3 working days, with a potential 14-day extension. ***42 CFR 438.408*** (a) –(c)	As quickly as the enrollee's health condition requires, but no later than 30 calendar days (involving a request for provision of a service) or 60 calendar days (involving a request for reimbursement for services received) after the plan receives the RFR, with a potential 14-day extension unless expedited resolution is granted then 72 hours with a potential 14-day extension. ***42 CFR 422.590(a), (b), (d)***
If plan denies appeal or fails to respond timely	Member entitled to appeal for State Fair Hearing if the plan denies the appeal. 42 CFR 438.408(f)(1)(i) (In some States, beneficiaries may appeal the original NOA directly to the State and receive a State Fair hearing. 42 CFR 438.408(f)(1)(ii)	If , upon reconsideration, the plan determines that it would uphold a decision adverse to the enrollee in whole or part, it must forward the file to the independent Entity (IE) contracting with CMS to perform reconsiderations no more than 30 days (in the case of a request for provision of services) or 60 days (in the case of a request for reimbursement for services received) after the RFR was filed. ***422.590 (a)(2)*** , (b)(2), (c).
Continuation of benefits		
Benefits continue during appeal if member files timely.	Yes, if member files within 10 days of the MCO mailing the NOA or prior to the effective date of the action, whichever is later. ***42 CFR 438.420***	No, for a standard reconsideration request as described above. Yes, in the case of an initial appeal of a termination of inpatient hospital services (422.622) ,if an expedited appeal is filed under the provisions of 422.622[4]
Plan Level Appeal		
	Some States allow beneficiaries to bypass plan appeal process and go	Plan level appeal required under standard reconsideration process.

[4] Also, in the case of skilled nursing facility (SNF) services, home health agency (HHA) services, and comprehensive outpatient rehabilitation (CORF services, while coverage is not extended by an appeal, beneficiaries have the right to independent review of a termination prior to the termination taking effect. Specifically, they are entitled to two days advance notice, and an opportunity to seek review during that two day period. In some cases, this review may not be completed, and beneficiaries would be liable for additional days if their appeal is not upheld.

	directly to a State Fair Hearing. 42 CFR 438.408(f)	In the case of an expedited appeal under 422.622 or 422.626, enrollees may appeal directly with an independent entity.
Termination or Reduction in service		
Plan must notify member in writing of proposed termination or reduction in service.	At least 10 days in advance (431.211, as incorporated in 438(c)(1)), unless an exception applies (431.213, 431.214).	Notice is required when inpatient hospital, SNF, HHA, or CORF services are to be terminated. 422.620, 422.624. In the case of SNF, HHA and CORF services, notice must be given 2 days before the proposed termination date. In the case of hospital services, notice must be issued the day before services would be terminated.

Conflicts between the Medicare and Medicaid appeal procedures should not pose a problem as long as (a) the principle of ensuring beneficiary access to Medicare appeals procedures for Medicare benefits and Medicaid appeals procedures for Medicaid covered benefits is applied, (b) duplicative appeals are avoided to the extent possible; ,and (c) where possible in cases where both appeal systems potentially would apply, the plan's grievance and appeal processes uses the procedural requirements of the more restrictive program (e.g., the Medicare timeframes) and apply the more liberal beneficiary protections (e.g., the Medicaid continuation of benefits policies).

One problem that will need to be addressed is what to do in cases where the wrong appeals process is selected (i.e., a Medicaid benefit covered only by Medicaid is processed using the Medicare external hearing process or vice versa). Presumably, the member would need to re-file the appeal under the correct appeal procedures. However, it is quite possible that by the time it is determined that the incorrect appeals procedures have been used, the time limits for filing under the correct procedures will have expired.

Model 1: Buy-In Wraparound Model

The MA Organization must comply with all Medicare Advantage appeal and grievance requirements. Medicaid would treat appeals as it does other Heath Insurance Premium Payment (HIPP) appeal and grievance requests. In this case, the MA Organization would operate under larger medical necessity criteria for its services by covering the Medicaid benefits under an optional supplemental benefit package. The Maximus Center for Health Dispute Resolution (Maximus CHDR) and the Administrative Law Judge (ALJ) would then treat the appeal as Medicare but follow Medicaid's expanded medical necessity criteria, because these would be reflected in the way the supplemental benefits were described.

Model 2: Capitated Wraparound Model

The appeals procedure could require that the health organization access both Medicare and Medicaid appeals processes (See Figure 10). Generally, coordination of the Medicare and Medicaid appeals processes can occur in two ways. One option would be initially to utilize the procedures of the primary payer (Medicare for Medicare-covered services and Medicaid for Medicaid wraparound services). A

second option would be initially to utilize the procedures of the program covering the benefit with the broadest medical necessity criteria. There is nothing, however, under either option that under regular rules would prohibit a dual-eligible beneficiary from filling simultaneous appeals for both Medicare and Medicaid, or from filing a Medicaid appeal even when Medicare is primary as long as the service is a Medicaid State Plan service. It may be to the beneficiary's advantage to do so, since Medicaid in most cases must continue the services pending the appeal. Until laws and/or regulations are enacted that coordinate the appeals process, or the appeal processes are coordinated through the waiver or demonstration authority, the beneficiary will have the right to pursue the appeal venue of his/her choosing.

There are two major issues that impede the coordination between the MA and Medicaid managed care appeals processes. First is the difference in timelines in the various stages of appeals. The Medicare Advantage regulations generally are more restrictive, requiring decisions by plans on appeals within 30 days of the receipt of appeal if the issue is services, 60 days if the issue is payment. In Medicaid, appeals must be resolved within 45 days of receipt of the appeals. For expedited appeals, Medicare requires resolution within 72 hours of receipt of request; Medicaid requires a decision within three working days. Both programs allow an extension of up to 14 days for a decision on an expedited appeal if the enrollee requests it or an MCO can demonstrate that there is a need for additional information and it is in the enrollee's interest.

The second issue affecting coordination is receipt of benefits while appealing a decision. If the decision being appealed is a termination or reduction in a previously authorized level of treatment, and the decision is appealed within 10 days of the mailing of the notice of the decision, then the Medicaid managed care regulations requires that the previously authorized level of treatment continue throughout the appeal. Medicare Advantage regulations do not allow for benefits to continue through an appeal except for inpatient hospital stays[5] A single model for both situations can address these issues. In this model, the beneficiary pursues an appeal through the plan's internal appeal process. The plan's appeal processes should follow the procedural requirements of the more restrictive program (e.g., typically the Medicare timeframes) and, whenever possible, the plan should apply the more liberal beneficiary protections (e.g., the Medicaid continuation of benefits policies). Whether a beneficiary would continue to receive a previously authorized level of treatment during the appeal could be determined by whether the service is covered by Medicaid.

If the beneficiary has proceeded through the plan's internal appeals process and is not satisfied with the final decision, he/she would proceed through Medicare's external appeals process if the service in question is a Medicare-primary covered service or through the Medicaid external process if the service is primarily Medicaid-covered. In its discussions, the CMS dual eligible workgroup expressed concerns about the ability of beneficiaries to determine whether Medicare or Medicaid is the primary payer. In the waiver/demonstration situation, officials from CMS and the State, in joint deliberation, could determine the primary payer status and notify the beneficiary of the correct avenue for appeal. In the non-

[5] As noted above, while benefits are not "continued" during an appeal from a termination of SNF, HHA and CORF services, beneficiaries have the right to appeal a termination before it becomes effective.

demonstration scenario, the organization would determine the primary payer status and advise the beneficiary, in its notice of final decision, of the correct avenue for appeal.

It may be extremely difficult to identify the primary payer in situations involving home health, therapy or durable medical equipment because of the overlap in those areas between Medicare and Medicaid. If it is not clearly a Medicare or Medicaid service (e.g. therapy or durable medical equipment), the organization must determine if Medicaid has broader coverage in that State for the purposes of a coverage decision. The organization would then send a denial for both the Medicare and Medicaid contracts, explaining the appeal rights in both systems. The organization also must note that Medicaid has continuation of benefits and broader coverage.

If the member chooses to accept the Medicare denial and pursues the Medicaid State fair hearing, the State Medicaid Agency may file an appeal with the Maximus Center for Health Dispute Resolution (Maximus CHDR) to determine whether or not Medicare has a role as the primary payer prior to finalizing the State fair hearing decision. The member could pursue a Medicare appeal and if denied could then pursue Medicaid. If the member pursues simultaneous Medicare and Medicaid appeals, the State Medicaid Agency should wait for the determination as to whether or not Medicare has a role as the primary payer prior to finalizing the State fair hearing decision.

For primary Medicare-covered services denied at the CHDR level and covered by Medicaid, the organization must determine whether the beneficiary would have further appeal rights under Medicaid. A State may decide to provide that the CHDR decision is deemed to constitute a Medicaid decision and notice of action as to Medicaid coverage as well, which would trigger Medicaid appeal rights. If this is not done, and the beneficiary still has time to file a timely appeal under Medicaid based on the original denial of service, he or she would also have Medicaid appeal rights. If the beneficiary has not timely filed a Medicaid appeal, however, and the State does not deem the CHDR decision to be a Medicaid decision for appeal purposes, the beneficiary would have no further appeal rights.

Under a demonstration project, a system could be established under which, when an appeal is filed that involves services potentially covered by Medicaid, it is deemed to be a Medicaid appeal for purposes of continuation of benefits. This would ensure that beneficiaries get the benefit of the Medicaid continuation of benefits provisions wherever possible. It could require, however uniformity in coverage standards. Also under demonstration authority, the demonstration could provide that where the beneficiary would have the right to both a Medicare and a Medicaid appeal with respect to the same underlying services, only one can be exercised. This could be accomplished by providing under demonstration authority that the right to a Medicaid appeal is waived to the extent it would duplicate a Medicare appeal that has been filed.

Model 3: Three-Party Integrated Model

PACE programs have their own statutory and regulatory authority for an appeal process (See Figure 11). Demonstration waiver programs implementing Model 3 could employ the single integrated appeals process discussed above. Figure 10 illustrates these options. For example, in the Wisconsin Partnership Program demonstration, the plan makes an initial determination as to whether the adverse coverage decision involves a Medicare or a Medicaid benefit and then immediately notifies designated officials at the State and CMS, who confer and either accept or modify the plan's determination, as appropriate. If the adverse coverage decision involves a Medicare benefit[6], an appeal will follow the Medicare regulations; if it involves a Medicaid benefit, Medicaid procedures are used. The advantage of this approach is that, because only one set of regulations will govern the appeal process, there will be no conflicts between the two programs' procedures.

The demonstration authority options discussed in the last paragraph of the discussion of Model 2 above could also be employed under a Model 3 program.

Model 4: Plan-Level Integrated Model

In this model, the plan must implement both Medicare and Medicaid appeal and grievance requirements. The plan may choose to adopt some of the integrative methods discussed under Model 2, above.

[6] Medicare is always the primary payer in this demonstration for benefits covered by both Medicare and Medicaid.

Figure 10. Appeals Model
(Coverage Decisions in Capitated Managed Care –Non-PACE)

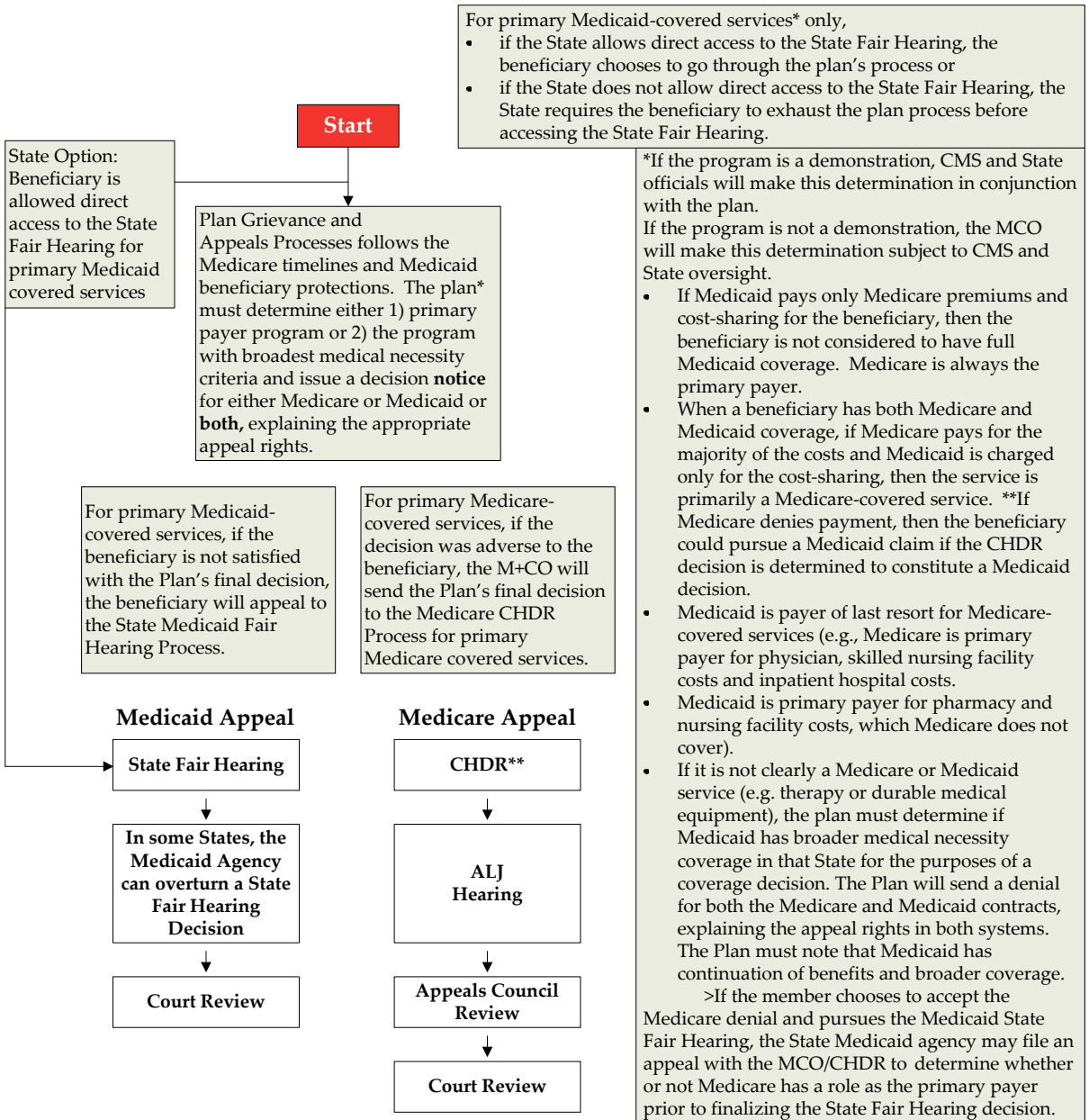
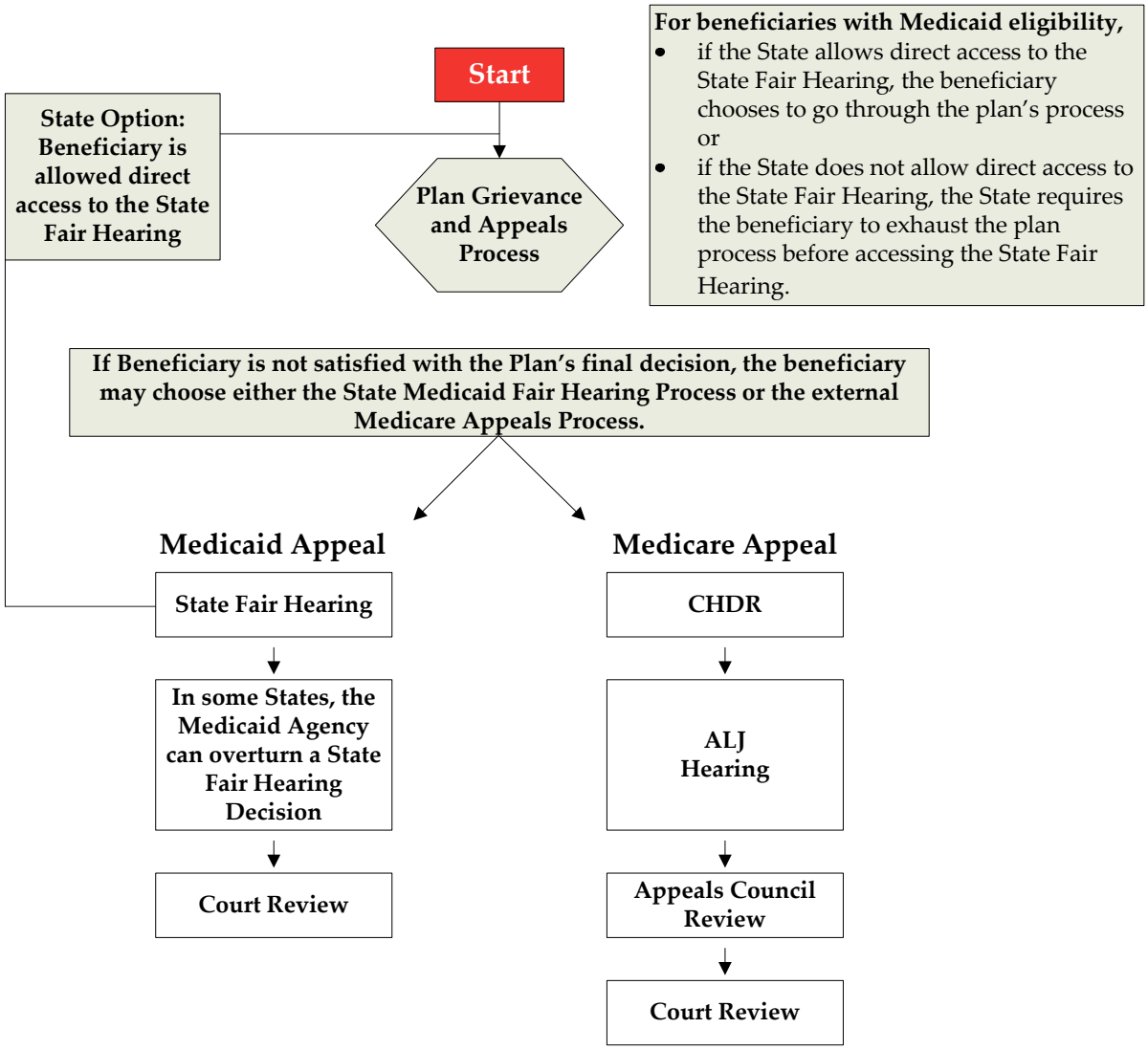


Figure 11. PACE Appeals Model



M. Quality Oversight

Model 1: Buy-In Wraparound Model

The organization would need to comply with all Medicare Advantage regulatory requirements.

Model 2: Capitated Wraparound Model

For medical care and quality oversight, CMS-Medicare would conduct MA access and quality monitoring. The State would conduct Medicaid monitoring. The State Medicaid Agency and CMS could have separate quality standards that the MA Organization must meet. However, the State Medicaid Agency could tailor the Medicaid contract provisions to meet both Medicare and Medicaid requirements, thereby minimizing the burden that separate requirements place on the organization. As for oversight of medical care and quality, CMS would conduct MA access and quality monitoring. The State would conduct Medicaid monitoring.

An External Quality Review (EQR) under Medicaid would be required if the organization were an MCO or PIHP. Based on the number of Medicaid services covered under the separate Medicaid contract, the organization may be classified as a Medicaid MCO. Note that States have the option to exempt MCOs and PIHPs from the EQR requirements if the organization has met the EQR requirements and holds a qualifying MA Plan for two consecutive years. If the organization is not exempt, States can use the Medicare quality review under the non-duplication provisions of the EQR regulations to reduce duplication of oversight. Indeed, the Medicaid State agency would be well advised to tailor the Medicaid contract provisions to meet both Medicare and Medicaid requirements, rather than mandating separate and distinct Medicaid requirements on these organizations. However, the organization must provide the State with all reports, findings and other results of the Medicare or accreditation review that are applicable to the EQR standards.

Model 3: Three-Party Integrated Model

This model best lends itself to coordination of quality oversight between the State Medicaid Agency and CMS-Medicare, as such coordination can be negotiated directly between CMS and the State Medicaid Agency as part of the waiver, contract and protocol negotiations, as it is in the PACE program. Indeed, it is anticipated that a single set of standards would be reflected in the joint contract.

PACE programs are excluded from EQR requirements. Under a demonstration, similar to Model 2, the organization may be considered an MCO and require an EQR. After two consecutive years of the MCO or PIHP meeting the EQRO requirements and holding a qualifying MA contract, a State might choose to exempt the MCO or PIHP from EQR requirements. Until that time, the State could use the Medicare quality review under the non-duplication provisions of the EQR regulations to reduce oversight duplication between Medicare and Medicaid. However, the MCO must provide the State with all reports, findings and other results of the Medicare or accreditation review that are applicable to the EQR standards.

Model 4: Plan-Level Integrated Model

Under this model, the organization would meet Medicare Advantage requirements and State Medicaid managed care requirements. The Medicaid contract provisions would probably be separate and distinct from any Medicare requirements on the organization.

N. MMA Implementation

General considerations applicable to all models

With the implementation of the MMA and the new Medicare prescription drug benefit under Part D of the MMA, more dual eligibles may wish to enroll in managed care organizations, because such organizations will be able to cover most Medicare services. States, in turn, may find it more attractive to work with Medicare managed care organizations to provide wraparound services in order to ensure a more seamless and coordinated system of care. Since Medicare will assume the coverage of most prescription drugs, States will want to ensure that dual eligibles do not "opt out" of the Medicare drug coverage, but rather receive drug coverage through enrollment in a Medicare Prescription Drug Plan (PDP) or, in the case of duals enrolled in an MA Plan, a Medicare Advantage Prescription Drug Plan (MA-PDP) operated by an MA Organization.