Strategy	**Medicare and Medicaid Integration**
Background:	There are more than 350,000 people in Texas who are eligible for both Medicare and Medicaid. These individuals are known as "dual eligibles." Many in this group have complex medical and chronic care needs that require lengthy stays in a variety of long-term settings. Effective care management for this population can best be accomplished when health plans can coordinate the entire continuum of health and long-term care services. Coordination of care is a challenge for dual eligibles who receive acute care services from Medicare and long-term care services through Medicaid. Medicaid and Medicare programs have differing incentives and approaches to client care and funding sources and payments. As separate and uncoordinated programs, each has incentives to shift client costs to the other program. For example, care management in Medicare might shift costs to long-term care services covered by Medicaid to reduce Medicare costs, and visa versa. Because of this bifurcation and the resulting dynamics, coordination for individuals in both programs to improve quality and efficiency of care is hindered. Growing awareness of the need for improved coordination and management across the continuum of care needs and programs has led to states and Centers for Medicare and Medicaid Services (CMS) pursuing alternative approaches for providing care to dual eligibles. CMS has provided new guidance to states and has relaxed some program restrictions to support improvements in program integration. *Options for Medicare/Medicaid Integration* Approaches to integrating programs for dual eligibles range from the coordination of benefits at the plan level to full integration at the state and federal government level. (See Page 5 for a graphic illustration of different approaches.) The new Integrated Care Management (ICM) model, which will be implemented in the Dallas/Fort Worth service delivery area, represents a managed fee-for-service approach. Medicaid and Medicare are reimbursed through fee for service payments and a service coordinator provides a link between the two programs. The Texas STAR+PLUS program represents a Medicare coordination approach, in which dual eligibles are enrolled on a mandatory basis in a capitated plan for Medicaid and are *encouraged* to enroll in the same health maintenance organization (HMO) for Medicare services. While the HMOs are able to leverage efficiencies and savings, one disadvantage of this model is that there is limited ability for the state Medicaid program to participate in the anticipated savings (typically in Medicare costs) achieved through improved coordination. A fully integrated approach involves a single contract with the HMO for Medicaid and Medicare. This model eliminates cost shifting between the Medicare and Medicaid programs and, if structured appropriately may allow the Medicaid program to share in the Medicare saving generated through reduced inpatient and

	emergency room use. If Texas pursued this option, it would need to work with CMS on a capitation rate for the Medicaid services that recognizes savings generated through the integration of funding and services. *Current Texas Program for Dual Eligibles* The STAR+PLUS program has encouraged the enrollment of dual eligibles in the same plan for Medicaid and Medicare for the last several years. The two current Harris County STAR+PLUS plans, Amerigroup and Evercare, have a Medicare special needs plan[1] and approximately 13,000 of the 30,000 dual eligibles enrolled in STAR+PLUS (43 percent) are members of these plans. Many of these members were passively enrolled in the Medicare special needs plans in January 2006. However, many other dual eligibles (approximately 8,000) who were passively enrolled last January have since disenrolled from the Medicare plan, returning to traditional Medicare. The primary reason reported for the disenrollment was that the member's primary care provider and/or specialists were not in the HMO network. In February 2007, the STAR+PLUS program will expand to cover almost 70,000 dual eligibles. Most of these dual members will be enrolled in traditional Medicare. The current Harris County plans, Evercare and Amerigroup, will offer special needs plans in the STAR+PLUS expansion areas they serve. The two new STAR+PLUS vendors, Superior and Molina, have indicated that they are interested in pursuing a Medicare special needs plan. Under the current STAR+PLUS contracts, STAR+PLUS plans cannot be required to offer a Medicare plan. Because of the STAR+PLUS expansion and recent procurements, adoption of this requirement would likely require contract re-procurement of the contracts or contract amendments prior to any extensions. Texas could choose to provide incentives for STAR+PLUS HMOs to develop special needs plans. These incentives could include assistance with Medicare marketing and enrollment and/or additional capitation to cover Medicare co-share obligations. It is likely, given the attractive Medicare rates for special needs plans, that all the STAR+PLUS plans will apply to offer a special needs plan even without a mandate.
Other States:	Other states have implemented models for dual eligibles that either coordinate services through the plans or fully integrate services at the state/CMS contract level. Below are some examples: Minnesota Senior Care Options (36,000 members). Fully integrated model Massachusetts Senior Care Options (6,000 members). Fully integrated model Wisconsin Partnership Model (10,000 members). Fully integrated model PACE (nationwide). Fully integrated model

[1] Special Needs Plan (SNPs) are a type of Medicare Advantage Plan that limits enrollment to only dual eligibles or an institutional population. SNPs are capitated Medicare managed care plans.

	Arizona (statewide). Coordinated model Florida LTC Diversion Program. Coordinated model Maryland Community Choices. Coordinated model
Application to Texas – Advantages & Disadvantages:	**Advantages of a Coordinated Model:** • Addresses the coordination needs of an aging population with more chronic care needs. • Consumers will receive all their services through one health plan reducing confusion and inefficiencies. • Improves access to services. • Promotes home and community based services and reduces institutionalization. • Plans have access to Medicare encounter data to help with care management;. • Can be accomplished without federal waivers. **Disadvantages of the Coordinated Model:** • Plans may coordinate for overall care management, but may use more Medicaid-funded services to do so. The state may see long-term service and support costs increase as the Medicare special needs plans utilize more of these Medicaid-funded services to prevent Medicare-funded hospitalizations and emergency room expenses. • Without a combined Medicare and Medicaid contract, the state will not be able to participate in the acute care savings. (These savings could be utilized to offset increases in long term services and supports utilization.) **Advantages of an Integrated Model:** • All the advantages of the coordinated model (with the exception of the need for federal waivers). • Texas could share in the saving generated by reductions in acute care services. **Disadvantages of the Integrated Model:** • Requires federal waivers, possibly including a Medicare 222 waiver that can take up to a year for approval. • CMS may be reluctant to share in the acute care Medicare savings (although other states have achieved favorable rates in their negotiations). **A consideration for both models** is that Medicare HMO participation is voluntary and members can switch out of the Medicare plan at any time.
Meets Medicaid	Cost Reduction or Avoidance: X; Maximizes federal funds: ; Improves Program Sustainability: ; Consumer Choice/ Responsibility:

Medicaid Reform Strategies for Texas

<table>
<tr><td rowspan="2">Reform Goal(s):</td><td>Reduces Number of Uninsured</td><td></td><td>Supports Private Market Coverage</td><td>X</td><td>Improves Quality</td><td>X</td><td>Improves Access</td><td>X</td></tr>
<tr><td>Benefit Options</td><td></td><td colspan="6"></td></tr>
<tr><td>Populations Affected:</td><td colspan="8">Consumers who are dually eligible for Medicaid and Medicare</td></tr>
<tr><td>General Revenue Impact:</td><td colspan="8">Savings are difficult to estimate because it would be a voluntary program for consumers on the Medicare side. More savings are expected with the integrated model, since the state could leverage the Medicare savings.</td></tr>
<tr><td rowspan="2">Other Considerations</td><td colspan="2">Stand Alone Option</td><td>X</td><td colspan="3">This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td>X</td></tr>
<tr><td colspan="8">Would need to coordinate strategy with STAR+PLUS and ICM.</td></tr>
<tr><td rowspan="4">State and Federal Approval(s) Required:</td><td rowspan="3">Federal</td><td>1115 Waiver</td><td></td><td rowspan="3">State</td><td>Rules</td><td>X</td></tr>
<tr><td>Other Waiver(s), [Medicare 222]</td><td>X</td><td>Legislation</td><td></td></tr>
<tr><td>State Plan Amendment</td><td></td><td colspan="2"></td></tr>
<tr><td>Implementation Considerations & Timeframes:</td><td colspan="8"><u>Affected Stakeholders</u>
• Service providers of dual eligible consumers
• Dual eligible clients
• HMOs
• Advocates for the aging population

<u>Systems and Resource Considerations</u>
• Similar to STAR+PLUS

<u>Other Considerations</u>
• Rate setting may be an issue with attempting to account for Medicare savings on the Medicaid side.

<u>Implementation Timeframes (in months)</u>
• 18 months</td></tr>
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RWFJ Medicare/Medicaid Integration Program