Review of Capitation for Certain Dual Eligible Clients

As Required by

2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 217)

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Executive Summary

The *Review of Capitation for Certain Dual Eligible Clients Report* is submitted in compliance with the 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 217).

Rider 217 requires HHSC to review the capitation amounts paid to health plans for Medicaid dual eligible clients, excluding capitation amounts for the STAR+PLUS and the Capitated Financial Alignment Demonstration (Dual Demonstration) programs. Dual eligible clients ("Dual Eligibles") are beneficiaries enrolled in both Medicaid and Medicare. A report on findings is due by December 31, 2017.

Other than STAR+PLUS and the Dual Demonstration programs (excluded from the review per Rider 217), HHSC pays Medicaid capitation rates for Dual Eligibles enrolled in the Program for All-Inclusive Care for the Elderly (PACE), Medicare Advantage Dual Special Needs Plans (D-SNPs), and contracted Medicare Advantage Plans (MAPs, non-D-SNP plans). HHSC has interpreted the intent of the rider to require a study of the rates paid to Medicare Advantage (MA) organizations that contract with HHSC ("vendors") as previous legislative action has addressed the development of PACE rates.

There are two kinds of Medicare Advantage Plans (also known as Medicare Part C) in Texas that coordinate with Medicaid:

- Traditional Medicare Advantage Plans (MAPs), and
- Medicare Advantage Special Need Plans (D-SNPs).

A D-SNP is a specialized MA plan that targets enrollment of Dual Eligibles. The traditional MAPs also enroll Dual Eligibles, but are not specialized plans. Federal regulations mandate that MA organizations seeking to offer a D-SNP within a state must obtain a contract with the state Medicaid agency. However, state Medicaid agencies are not required to offer D-SNPs in their state. Vendors can chose to contract with HHSC to provide MAPs, but are not required to do so.

HHSC contracts with MAP/D-SNP vendors in order to cover its obligation under the Texas State Plan to pay for Medicare member coinsurance, co-payments, and deductibles for certain Dual Eligibles ("member cost-sharing"), for persons not

enrolled in fully integrated plans. See Table 2 for a matrix of plan characteristics. HHSC also contracts with a third party to pay similar member cost sharing on a fee for service basis for clients neither enrolled in a fully integrated plan nor a MAP/D-SNP.

Notable information from the report includes:

- In Texas, payments to the vendors are made under a capitated arrangement, currently $10 per member per month (PMPM).
- In FY 2017, vendors received a total of $16 million (all funds), of which $7 million was general revenue, in capitation payments from HHSC.
- The capitation payment is intended to be a contractual payment whereby HHSC and the vendor agrees that for a set rate, the vendor accepts the payment as compensation for the member cost-sharing obligations. HHSC has no further obligation to pay for member cost-sharing for these members.
- States have the option to contract to cover a variety of Medicaid benefits, such as member cost-sharing and Medicaid only services (an approach to further develop integrated care). However, HHSC has chosen to contract solely for the member cost-sharing obligation required to be paid by Medicaid.
- Medicare premiums, Medicaid only services (wrap-around services), and coinsurance for Part A-like services provided during a Dual Eligible's Medicare-covered stay in a nursing facility are not included in these contracts, and continue to be HHSC's financial responsibility.
- HHSC enters into agreements with these vendors, at a $10 PMPM rate, in the following manner:
    - Medicare Advantage Plans (MAP) that chose to contract with HHSC. The MAP is not required to contract with the state Medicaid agency, but has chosen to do so. If the MAP does not contract with HHSC, then the member cost-sharing obligations are paid by HHSC through Texas Medicaid and Healthcare Partnership (TMHP) as cross-over claims.
    - Medicare Advantage Dual Special Needs Plans (D-SNP) that are required to contract with HHSC and have a companion Medicaid plan (such as the STAR+PLUS product).
    - Medicare Advantage Dual Special Needs Plans (D-SNP) that are required to contract with HHSC and do not have a companion Medicaid plan.
- The MAP and D-SNP programs are partially integrated programs for Dual Eligibles, and differ from the vast majority of managed care programs administered by HHSC.
    - These health plans are responsible for administering the Medicare covered services, primarily hospital, physician and pharmacy services. These

contracts do not include financial responsibility for Medicaid only services (wrap-around), such as institutional care and long-term services and supports.

  - Medicare is the primary payer for Dual Eligibles' hospital, physician and pharmacy services. The Medicaid obligation for member cost-sharing is relatively small compared to the Medicare financial responsibility for these services.

- In order to evaluate the capitation rates paid to the vendors, HHSC would need the following information:
  - Data or financial reporting identifying only the coinsurance, co-payment, and deductible expenses, and
  - Medicare premiums and overall financial performance of the MAP or D-SNP.
  - A method for verifying the above information.
- Comprehensive and reliable financial data needed to evaluate the overall financial performance of MA vendor organizations is not currently available to HHSC nor required by CMS.
- HHSC anticipates that adding audits and the other tools and efforts necessary to obtain and review cost data would result in additional costs to the state, which would be significant relative to the size of this program.
- Given these financial challenges and lack of comprehensive data, HHSC plans to maintain the current pmpm rate.

1. Introduction

Rider 217 directs HHSC to review the capitation amounts paid to health plans for Medicaid dual eligible members, excluding capitation amounts for the STAR+PLUS and Dual Demonstration programs. A report must be submitted December 31, 2017, to the LBB.

HHSC contracts with vendors to offer two kinds of Medicare Advantage Plans (also known as Medicare Part C) that coordinate with Medicaid:

- Traditional Medicare Advantage Plans (MAPs) and
- Medicare Advantage Special Need Plans (D-SNPs).

The vendors through their contracts with the Centers for Medicare and Medicaid Services (CMS) contract with providers for Medicare-covered services. Dual Eligibles enrolled in a D-SNP or MAP receive their institutional care and long-term services and supports though the STAR+PLUS Medicaid managed care program. In accordance with the Texas State Plan, Medicaid is financially responsible for the member cost-sharing obligations attributable to the Dual Eligibles enrolled in the MAPs and D-SNPs. In order to fulfill this requirement, HHSC pays the vendor a monthly PMPM capitated payment in exchange for the vendor's payment of member cost-sharing obligations (deductibles, coinsurance, and co-payments) to healthcare providers for Medicare-covered services.

In Texas, payments to all vendors are made under a capitated arrangement, currently $10 PMPM. Most of these vendors are MCOs (or affiliate companies) that contract with HHSC to deliver Medicaid managed care services in the STAR+PLUS and Dual Demonstration programs. If the MA organization does not contract with HHSC, then the member cost-sharing obligations are paid by HHSC through TMHP as cross-over claims.

Presently, HHSC contracts with ten vendors, for MAPs and D-SNPs. In FY 2017, HHSC paid $16 million (all funds), of which $7 million was general revenue for 135,000 enrollees (Table 1). Vendors must contract with HHSC to offer D-SNPs. However, MAPs are not subject to the same requirement, but vendors may contract with HHSC by choice.

HHSC pays over $20 billion in capitation payments each year, using general revenue and matching federal funds. The capitation payments to these vendors represents less than 0.1 percent of total capitation payments made by HHSC.

Table 1. Contracted MA Organizations' Historical Membership and Capitation Payments*

	Average Monthly Membership	PMPM	All Funds	General Revenue
FY 2016	111,407	$10.00	$13,368,860	$5,720,535
FY 2017	135,354	$10.00	$16,242,520	$7,104,478

*September 2017 Operating Budget

2. Background

HHSC Managed Care Programs for Dual Eligibles

Clients who are dually eligible for Medicaid and Medicare services are enrolled in one of three Medicaid managed care programs in Texas: STAR+PLUS, the Dual Demonstration, or a PACE program. The PACE and Dual Demonstration programs are fully integrated programs, meaning a single health plan coordinates and is financially obligated to cover both Medicaid and Medicare benefits. Therefore, Dual Eligibles in PACE or the Dual Demonstration cannot also enroll in a MAP or D-SNP.

The STAR+PLUS program is not fully integrated and clients in the STAR+PLUS program only receive long-term services and supports (e.g. attendant care), or institutional care (e.g. nursing facility care) though this program. The remaining obligations for Medicaid costs (Medicaid only services and member cost-sharing) are paid separately. For STAR+PLUS clients, all Medicaid only services are paid on a fee for service basis by HHSC. Member cost sharing payment will depend on whether or not the client is enrolled in a contracted MAP/D-SNP. If the STAR+PLUS client is also enrolled in a contracted MAP/D-SNP, then HHSC pays the vendor a capitation rate and the vendors pays the member cost sharing obligation. If the STAR+PLUS client is not enrolled in a contracted MAP/D-SNP, then the member cost-sharing (and Medicaid only services) are paid by HHSC on a fee for service basis. STAR+PLUS clients enroll in a MAP/D-SNP voluntarily.

Table 2, on the following page, provides a brief description of these programs and the financial obligations included in the capitation rates paid by HHSC. Member cost-sharing is the only Medicaid benefit included in the MAP/D-SNP capitated agreement between HHSC and the vendors. The Dual Demonstration capitation rates include all Medicaid benefits (long-term services and supports, institutional care, Medicaid-only services, and member cost-sharing), of which member cost-sharing is a small component of the overall capitation rate.

Table 2. HHSC Programs for Dual Eligibles

Program	Description	Capitated Services/Benefits
Program of All-Inclusive Care for the Elderly The Program of All-Inclusive Care for the Elderly (PACE)	A fully integrated approach, providing an array of services for a capitated monthly fee below the cost of comparable institutional care. PACE participants must be age 55 or older, live in a PACE service area, qualify for NF level of care, and be able to live safely in the community at the time of enrollment.	All Medicaid services, including long-term care services and supports, Medicaid only services, and member cost-sharing.
Dual Demonstration	The Dual Eligible Integrated Care Demonstration Project, also referred to as the Dual Demonstration, is a fully integrated managed care model for individuals age 21 or older who are dually eligible for Medicare and Medicaid and required to receive Medicaid services through the STAR+PLUS program. To be eligible the individual must reside in one of the six Dual Demonstration counties.	All Medicaid services, including long-term care services and supports, Medicaid only services, and member cost-sharing.
STAR+PLUS	The STAR+PLUS program is a Medicaid managed care program for individuals who are age 65 or older or have a disability. Dual Eligible individuals receive institutional care and long-term services and supports (LTSS) through STAR+PLUS. Services include nursing facilty care, attendant care and day activity and healthcare services (DAHS).	Institutional care and long-term care services and supports.*
Medicare Advantage Dual Eligible Special Needs Plan	A Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals that are dually eligible for both programs.	Member cost-sharing only.

* Medicaid-only services and member cost-sharing costs are excluded from STAR+PLUS capitation.
Medicaid only services are paid on a fee for service basis by HHSC.
Member cost-sharing is paid by HHSC on a fee for service basis, if the client is not enrolled in a contracted MAP or D-SNP.
Member cost-sharing is paid by the MAP or D-SNP, if the client is enrolled in a contracted MAP or D-SNP.

Medicare Advantage Plans and Dual Special Needs Plans

Medicare Advantage plans (formerly known as Medicare+Choice Plans) were established in the late 1990s to allow private health insurance companies to provide Medicare services through a Managed care model. However, plans lacked coordination of care for those individuals receiving both Medicare and Medicaid (Dual Eligibles). In an effort to improve coordination between Medicare and Medicaid services, Congress enacted the Medicare Modernization Act of 2003 to allow Medicare Advantage plans to target enrollment for specific populations and improve coordination of care for Dual Eligibles. This Act led to the development of Medicare Advantage (MA) D-SNPs.

D-SNPs are one of three types of Special Needs Plans (SNPs) authorized in the Medicare Modernization Act of 2003. Prior to the authorization of SNPs, MA organizations were not permitted to limit enrollment to specific types of individuals receiving Medicare services. SNPs target enrollment to 3 specific vulnerable populations:

- Individuals who are dually eligible for Medicare and Medicaid (D-SNPs)
- Individuals who live in long-term care institutions (I-SNP)

- Individuals with a severe or disabling chronic condition (C-SNP)

D-SNPs are intended to allow services and models of care that better meet the needs of Dual Eligibles. D-SNPs can provide better coordination of services for clients that are dually enrolled in Medicare and Medicaid. Initially, there was no requirement that D-SNPs have any formal relationship with state Medicaid agencies. However, in 2008 the Medicare Improvements for Patients and Providers Act (MIPPA) was enacted, which required D-SNPs to have a contract and meet minimum contract requirements with the state Medicaid agency in each state in which they operate.

CMS Oversight and Medicare Premiums

The MAP and D-SNP application and selection process is administered by CMS. CMS has rigorous requirements for these vendors including network adequacy, contract oversight, and quality monitoring.

MAP and D-SNP Medicare premium payments are determined through a bid process. On an annual basis, MA organizations submit bids to CMS requesting payment rates based on the estimated cost of providing Medicare services for clients in their MAPs and D-SNPs. The bids are compared to benchmark amounts that are set by formula and vary by county. If the bid is lower than the benchmark the MA organization has an opportunity to retain a portion of the difference, known as a "rebate" which can be used to provide supplemental benefits. The Affordable Care Act reduced benchmarks and rebates, but allowed plans with higher quality ratings to retain a larger portion of the rebate amounts than plans with lower quality ratings.

HHSC MAP and D-SNP Contracts

HHSC contracts with the MA organizations, at a $10 PMPM rate, in the following manner:

- Medicare Advantage Plans (MAP) that have the option to contract with HHSC. The MAP is not required to contract with HHSC, but has chosen to do so.

- Medicare Advantage Dual Special Needs Plans (D-SNP) that are required to contract with HHSC, and have also contracted with HHSC to provide a companion Medicaid plan*(such as the STAR+PLUS product).

- Medicare Advantage Dual Special Needs Plans (D-SNP) that are required to contract with HHSC, but which do not have a companion Medicaid plan*.

(* Note: HHSC requires STAR+PLUS Medicaid plans to offer a D-SNP, but HHSC will contract with D-SNPs that do not have a companion Medicaid plan.)

Eligibility for MAP or D-SNP

As defined in the Texas State Plan, enrollment into a MAP or D-SNP is limited to Medicare managed care recipients who are also enrolled in Medicaid, and for whom the State has a responsibility for payment of member cost-sharing under the Texas State Plan. Table 3, on page 11, provides information on the different categories of dual eligible Medicaid programs. The categories of Dual Eligibles covered by this provision of the Texas State Plan: are limited to the shaded programs in Table 3: QMB Only, QMB Plus, and SLMB Plus.

Dual Eligible Benefits Coverage

The vendors, through their contracts with CMS, contract with providers to provide Medicare-covered services, such as hospital, physician and pharmacy services. Dual Eligibles receive their institutional care and long-term care services and supports though the STAR+PLUS Medicaid managed care program.

States have the option to cover a variety of Medicaid benefits in the MAP and D-SNP contracts, such as member cost-sharing, Medicaid only benefits (wrap-around), or supplemental benefits. HHSC contracts with vendors to cover the member cost sharing obligations required to be paid by Medicaid for Dual Eligibles, only. Member cost-sharing obligations that the vendors must cover are financial payment obligations incurred in satisfaction of the deductibles, coinsurance, and co-payments for the Medicare Part A and Part B programs. Member cost-sharing obligations do not include: (1) Medicare premiums required to be paid by HHSC under the Texas State Plan on behalf of Dual Eligibles, (2) Wrap-around services that are covered by Medicaid but not Medicare, and (3) Coinsurance for Part A-like services provided during a Dual Eligibles Medicare-covered stay in a nursing facility. HHSC continues to pay for these costs separately.

Capitation Payments for Member Cost-sharing Obligations

The capitation rate paid to the vendors serves as an incentive to contract with HHSC, and as a fixed contractual payment whereby HHSC and vendors agree that

in exchange for a set rate and corresponding monthly payment from HHSC, the vendors absorb and cover the Medicaid obligation for member cost-sharing requirements.

HHSC began contracting with MAPs and D-SNPs in 2008, at a rate of $25 PMPM. Effective January 1, 2012, the rate was reduced to $10 PMPM due to Medicare Equalization. The 2012-13 General Appropriations Act directed HHSC to implement Medicare Equalization as a cost containment initiative, in order to align state costs for Dual Eligibles with those for Medicaid only members. This policy limits payments for Medicare Part B services provided to qualified Dual Eligibles to no more than the Medicaid payment amount for the same service, as allowed by federal law. This change had the following impacts:

- If the Medicare payment amount equaled or exceeded the Medicaid payment rate, HHSC would not make a cost-sharing payment.

- If the Medicare payment amount was less than the Medicaid payment rate, HHSC would pay the lesser of: (1) the Medicare deductible/coinsurance amount; or (2) the difference between the Medicaid rate and the Medicare payment amount.

- HHSC made some adjustments to the policy or excluded from the policy certain services, like cancer medications, renal dialysis facility services, and emergency ambulance services.

In conjunction with this, the capitation rate was reduced to $10 PMPM in anticipation that these changes would result in a significant reduction in the cost of member cost-sharing obligation. As with all capitated arrangements, HHSC offers the capitation payment rate and the vendors can decide whether or not they want to participate.

Table 3. Dual Eligible Clients

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Benefits
Full Medicaid (only)	Determined by State	Determined by State	Not applicable (N/A)	• Full Medicaid coverage either through mandatory coverage groups (for example, Supplemental Security Income (SSI) recipients) or optional coverage groups such as the "special income level" group for institutionalized individuals or home- and community-based waiver participants and "medically needy" individuals • Medicaid may pay for Part A (if any) and Part B premiums and cost sharing for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan
QMB Only	≤100% of Federal Poverty Line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index (CPI)	Part A***	• Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)
QMB Plus	≤100% of FPL	Determined by State	Part A***	• Full Medicaid coverage • Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)
SLMB Only	>100% of FPL but <120% of FPL	≤3 times SSI resource limit, adjusted annually in accordance with increases in CPI	Part A	• Medicaid pays for Part B premiums
SLMB Plus	>100% of FPL but <120% of FPL	Determined by State	Part A***	• Full Medicaid coverage • Medicaid pays for Part B premiums
QI**	≥120% of FPL but <135% of FPL	≤3 times SSI resource limit, adjusted annually in accordance with increases in CPI	Part A	• Medicaid pays for Part B premiums
QDWI	≤200% of FPL	≤2 times SSI resource limit	Part A benefits lost due to individual's return to work; eligible to enroll in and purchase Part A coverage	• Medicaid pays for Part A premiums

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Social Security Act (the Act).
** Beneficiaries under this program are not otherwise eligible for full Medicaid coverage through the State.
*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis").

3. Review

The MAP and D-SNP programs are partially integrated programs, and differ from the vast majority of managed care programs administered by HHSC. The vendors are financially responsible for the Medicare covered services, and Medicare is the primary payer for hospital, physician and pharmacy services. The Medicaid obligation to cover member cost-sharing is a relatively small amount, compared to the Medicare financial responsibility for these services.

In order to evaluate the capitation rates paid to the vendors, HHSC would need the following information:

1. Data or financial reporting identifying only the coinsurance, co-payments, and deductible expenses, and

2. MAP or D-SNP Medicare premiums, bid information, and overall financial performance of the MAP or D-SNP.

Item one above, requires that the vendors have a system that can parse the Medicaid and Medicare portions of the claims experience, to determine the claims amount attributable to co-payments, deductibles, and coinsurance. Additionally, HHSC would need information on the vendors' overall financial performance for these plans, including Medicare, because the vendor can use Medicare revenues to reduce member cost-sharing obligations (e.g. Medicaid financial obligations). Both Medicare and Medicaid data are needed to determine whether or not a capitation rate is insufficient or overly generous to meet the needs of the vendor.

HHSC has collected limited financial information from the vendors, on a self-reported basis. Through that process HHSC learned that not all vendors are able to report co-payments, deductibles and coinsurance (the Medicaid obligation) separately from the Medicare portion of the expenses. Results varied considerably by MA organization, indicating that the information that had been submitted was not determined in a uniform manner. HHSC was unable to verify or audit the reported data. Overall, comprehensive and reliable financial data needed to evaluate the comprehensive financial performance of MA vendor organizations is not currently available to HHSC nor required by CMS.

HHSC staff also collected information on D-SNPs in other states. A review of this information did not provide results that could be used in this study. The two primary issues were differences in the populations enrolled in D-SNPs, and the services included in the capitated agreements in the other states. Each state determines the services that are included in the DSNP's financial responsibly. States can elect to include Medicaid benefits covered in the vendor's contract. States may choose to not include any Medicaid benefits in these contracts, meaning the vendor has no financial responsibility to cover Medicaid costs. In this case, the state pays the Medicaid obligations through a separate mechanism. Or states may choose to include responsibility for member cost-sharing and/or Medicaid only services. Most states that include member cost-sharing in the agreement also include Medicaid-only services, and do not have the costs separately identifiable. In summary, there exists a significant amount of variability among states regarding the scope of Medicaid benefits provided or arranged for by the D-SNP.

In order to understand the actual financial impact of member cost-sharing obligations, HHSC would need to take the following steps:

- Amend the contracts to require financial and encounter data reporting, to include Medicare and Medicaid revenues and expenses, as well as audits.
- Amend the contracts to require vendors to submit CMS-Medicare-required financial reports, including information provided to CMS as part of the Medicare Advantage bid and cost reporting processes, and possibly other financial data.
- Develop a MAP and D-SNP financial reporting tool.
- Make information technology changes to collect encounter data from the vendors.
- Develop a process to reconcile, review and audit the financial and encounter reporting.
- Work with the vendors to develop an encounter data reporting system that accurately reports only the member cost-sharing portion of claims, and where encounters match reported financial amounts within an acceptable tolerance range.
- Procure and conduct audit services.

Each of these tasks can be completed with additional resources and time to establish contracting requirements and procedures. Specifically, HHSC anticipates

significant cost due to data review and contracted audit processes, services and staffing needs to adequately manage said processes.

The vendors would need to be able to accurately report the Medicaid financial responsibility and administrative expense separately from the Medicare expense. It is unknown if all of the vendors have the infrastructure or ability to support this type of reporting or would determine the incremental cost or reporting to be cost effective.

Given these financial challenges and lack of comprehensive data, HHSC plans to maintain the current pmpm rate.

4. Conclusion

Rider 217 directs HHSC to study the capitation rates paid for dual eligible clients not enrolled in STAR+PLUS or the Dual Demonstration. While states have the option to contract with MA organizations to cover a variety of Medicaid Services (an approach to further develop integrated care), HHSC has chosen to include member cost-sharing obligations that are required to be paid by Medicaid for Dual Eligibles in its contracts with vendors. Currently, HHSC pays $10 PMPM for each client enrolled in a MAP or D-SNP to provide an incentive for the MA organization to contract with HHSC, and to recognize there may be costs associated with member cost-sharing which are a Medicaid cost. In order to evaluate the sufficiency of the $10 PMPM payment, HHSC would need to develop processes and secure resources needed to collect, review, and audit the vendors' financial data. Increasing the level of oversight and reporting would produce additional costs to the state, which would be relatively large compared to the size of this program at this time.

List of Acronyms

Acronym	Full Name
CMS	Centers for Medicare and Medicaid Services
D-SNP	Dual Special Needs Plan
FY	Fiscal Year
HHSC	Health and Human Services Commission
LBB	Legislative Budget Board
MA	Medicare Advantage
MAP	Medicare Advantage Plan
MIPPA	Medicare Improvements For Patients and Providers Act
PACE	Program for All-Inclusive Care for the Elderly
PMPM	Per Member Per Month
SLMB	Specified Low Income Medicare Beneficiary
SNP	Special Needs Plan
TMHP	Texas Medicaid and Healthcare Partnership
QMB	Qualified Medicare Beneficiary

Appendix A. Glossary

GLOSSARY

MEDICARE PART C (MEDICARE ADVANTAGE) - Previously called Medicare+Choice, Medicare Part C was renamed Medicare Advantage and modified by the Medicare Prescription Drug Improvement and Modernization Act of 2003. It provides for certain managed care coverage options in Medicare, under which managed care organizations receive a capitated monthly payment per covered beneficiary. Additional benefits and cost-sharing arrangements may be offered by Medicare managed care organizations.

DUAL SPECIAL NEEDS PLAN - A Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to provide targeted care to individuals who are dually eligible for both Medicare and Medicaid. D-SNPs are responsible for the coordination of care between Medicare- and Medicaid-covered services. Eligible individuals who live in an area in which these MA plans operate may choose to receive their Medicare and Medicaid services through such a plan. Under this managed care delivery option, D-SNPs are responsible for the coordination of care between Medicare and Medicaid covered services. D-SNPs that also operate in STAR+PLUS deliver Medicaid services through the STAR+PLUS program. D-SNPs that do not also operate in STAR+PLUS are only responsible for paying beneficiary cost-sharing.