HEALTH REFORM IMPACT

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Dual Goals For Dual Eligibles: Improved Care and Lower Costs

May 25, 2011

The Centers for Medicare & Medicaid Services ("CMS") has recently announced four initiatives aimed at giving states increased flexibility to "adopt innovative new practices and provide better, more coordinated care" to Medicare and Medicaid enrollees who are eligible for benefits under both programs (the "dual eligibles").[1] CMS hopes that these initiatives will, in addition to improving care, help "reduce costs for states and families." This issue of *Health Reform IMPACT* briefly highlights each of these initiatives.

(1) Medicare-Medicaid Coordination

One of CMS' recently announced initiatives is to enhance coordinated care for dual eligibles. This initiative includes funding for 15 states, including Tennessee, to develop demonstration projects for coordinated care. This initiative also includes a proposed rule, published in the Federal Register on May 16, 2011, soliciting input on ways to align the sometimes conflicting requirements and program features of Medicare and Medicaid.

Background

Dual eligibles tend to be the lowest income and most chronically ill of the nation's citizens. While the Medicare and Medicaid programs tend to cover different patient populations, there are approximately 9.2 million dual eligibles in the United States, representing 16 percent of Medicare beneficiaries and 27 percent of Medicare costs. Similarly, dual eligibles constitute 15 percent of Medicaid enrollees, but account for 39 percent of the program's costs. More than half of dual eligible beneficiaries have incomes below the poverty level.

According to CMS, "beneficiaries who are in both Medicare and Medicaid can face different benefit plans, different rules for how to get those benefits and potential conflicts in care plans among providers who do not coordinate with each other." This situation, states CMS, "can be disastrous for those beneficiaries who are most vulnerable and in need of help."[2]

[1] See April 14, 2011 CMS-issued Press Release.
[2] http://www.hhs.gov/news/press/2011pres/04/20110414a.html

Demonstration Projects

The demonstration project initiative, authorized by Section 2602 of the Patient Protection and Affordable Care Act ("PPACA"), offers funding to 15 states[3] to design demonstration projects aimed at improving coordination of care for dual eligibles. CMS is looking to these 15 states to develop creative ways to provide more efficient and less confusing healthcare to the dual eligibles. The goal is to eliminate duplication of services, expand access to care and improve the lives of dual eligibles, all while lowering costs. Under the program, each of these states will receive up to $1 million to develop "person-centered" demonstration projects, the focus of which will be coordinating primary care, acute care, behavioral health services and long-term care for dual eligibles.

The demonstration projects will continue for 18 months, during which the states will work with the Federal Coordinated Health Care Office (also known as the "Medicare-Medicaid Coordination Office"), an entity within CMS created by PPACA. At the end of 12 months, the states' proposals will be due. The remaining six months of the 18-month period will be used by CMS to review the demonstration proposals and pursue possible implementation strategies with the states that have the most promising proposals.[4]

Alignment Initiative

In addition to the demonstration projects, CMS recently released a proposed rule[5] requesting comments on an alignment initiative that has goals similar to the demonstration project initiative. Specifically, the proposed rule identifies a list of areas in which the Medicare and Medicaid programs have conflicting requirements that, in CMS' view, prevent dual eligible individuals from receiving seamless, high quality care. CMS is seeking ideas on how to align these conflicting areas, which can broadly be characterized into the following topics: (1) coordinated care; (2) fee for services benefits; (3) prescription drugs; (4) cost sharing; (5) enrollment; and (6) appeals. Comments are requested by July 11, 2011.

(2) Disabled Beneficiaries' Opportunity for Community Living

In a proposed rule released on April 15, 2011[6], CMS announces its intent to facilitate the provision by state Medicaid programs of home and community based services ("HCBS"), thereby enabling more disabled beneficiaries to live in the community rather than in an institution. In doing so, CMS continues moving toward "person-centered" programming (and away from diagnosis-based programming), an overarching theme evidenced throughout CMS' recent initiatives.

The proposed regulations would allow states to target multiple groups in a single HCBS waiver (under current rules, only one target group may be served per waiver).[7] CMS has acknowledged that the current rules create administrative difficulties, time delays and barriers for disabled persons to transition to or remain in community living. The proposed multi-target group waiver projects could include the following beneficiary categories: (1) the aged or disabled; (2) persons with developmental disability; and (3) those with mental illness. Such a change is needed, according to CMS, to adjust to the reality of the living situations of many Medicaid beneficiaries. Specifically, CMS

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[3] The 15 states are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin.
[4] See CMS-issued RFP-State Demonstrations to Integrate Care for Dual Eligibles – Design Contracts.
[5] 76 Fed. Reg. 28196-7 (May 16, 2011).
[6] 76 Fed. Reg. 21311 (April 15, 2011).
[7] Waivers exempt states from certain Medicaid statutory requirements so that a state may offer HCBS to specified groups of beneficiaries who otherwise would require services at an institutional level of care

gave as an example the growing number of beneficiaries with intellectual disabilities who reside with aging caregivers (typically their parents) who are often aged or disabled Medicaid beneficiaries. The proposed change would enable the state to design a coordinated waiver program that meets the needs of the intellectually disabled beneficiary and his or her aged parent.

The proposed rule clarifies that an HCBS setting is not consistent with segregated settings or settings with a strong "institutional nature." Rather, home and community based housing is intended to integrate beneficiaries into mainstream housing. Therefore, HCBS settings may not be located on the campus of a facility that provides institutional treatment or custodial care, and housing complexes designed expressly for persons with disabilities will not qualify as HCBS. HCBS must be integrated into the community and must not have qualities of an institutional facility such as regimented meal and sleep times, limitations on visitors or lack of privacy. However, in certain circumstances, assisted living facilities and retirement communities may be an acceptable location for HCBS waiver programs.

(3) Help to States in Preparing for 2014 Medicaid Program Expansion and Improvements

CMS also announced on April 14, 2011, and published in the Federal Register on April 29, 2011, a final rule[8] pursuant to which all states will be eligible to receive funding to develop simpler and more efficient information technology systems to modernize Medicaid enrollment. Specifically, states that need to overhaul their information technology systems to handle the expansion and changes in Medicaid enrollment required under PPACA will have 90 percent of the cost paid for by the federal government. The updated systems also will assist states in preparing for the development of the new Insurance Exchanges to be implemented under PPACA.

Under PPACA, most Americans whose income is up to 133 percent of the federal poverty level will be eligible for Medicaid in 2014. Further, under PPACA, the rules for enrolling new beneficiaries and for determining eligibility will be modified, requiring significant system transformation to the states' information technology systems. Among other requirements, states will need to apply new rules to determine eligibility, enroll large numbers of new beneficiaries, renew eligibility for exiting enrollees and operate seamlessly with the impending Health Insurance Exchanges.

The 90 percent federal matching rate to assist states in the design, development, installation or enhancement of the Medicaid eligibility systems will be in effect through December 31, 2015. After that time, states may be able to receive enhanced federal support at the 75 percent match rate for system maintenance and operations. To receive the enhanced match (that is, the amount over the 50 percent standard Federal Financial Participation match available for administrative expenses), the Secretary of the Department of Health and Human Services must find that the new claims and information retrieval system is likely to contribute to efficient, economical and effective administration of the state plan. Specific performance metrics, as well as program and policy requirements, will be issued in separate, forthcoming notices.

(4) Expanding Health Coverage in New Jersey

CMS announced the approval of a Section 1115 demonstration (an "expansion waiver") for New Jersey that will, by December 2013, expand healthcare coverage to nearly 70,000 people, 10,000 of whom are currently uninsured. Specifically, the waiver will allow New Jersey to collect reimbursement from the federal government for some of the cost of providing health insurance to

[8] 76 Fed. Reg. 21950 (April 19, 2011).

approximately 57,000 single, childless adults currently participating in the Work First New Jersey program. The healthcare benefits for these beneficiaries previously were provided through a Medicaid-type program but issued with state-only funds.

The waiver creates a new federally-approved Medicaid category in New Jersey that allows the state to seek 50 percent federal reimbursement, which is the standard Federal Financial Participation amount. The waiver also allows for growth in the program to 70,000 beneficiaries through December 2013. The budgetary savings for the state of New Jersey under this expansion waiver are estimated at $88 million for 2012.

If you have any questions regarding this issue of *Health Reform IMPACT*, please contact any of the attorneys in our Healthcare Practice Group below.

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