



## A NEW STATE PLAN OPTION TO INTEGRATE CARE AND FINANCING FOR PERSONS DUALY ELIGIBLE FOR MEDICARE AND MEDICAID

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### I. BACKGROUND<sup>1</sup>

#### *Dual eligible populations and costs*

As health care costs continue to escalate, Congress, the U.S. Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, researchers, and policymakers are focusing on identifying new approaches to care delivery and reimbursement for individuals who are dually eligible for both Medicare and Medicaid. Although relatively few in number (9 million), dual eligible beneficiaries are more likely than others to experience poor health, including multiple chronic conditions, functional and cognitive impairments, and a need for continuous care. Sixty-six percent of dual eligibles have three or more chronic conditions; sixty-one percent are considered to be cognitively or mentally impaired.<sup>2</sup> As a result, the dual eligible population, as a whole, is very expensive for both the Medicare and Medicaid programs.<sup>3</sup> In 2006, dual eligible beneficiaries accounted for approximately \$230 billion in federal and state spending.<sup>4</sup> This represented almost 36 percent of total Medicare spending and 39 percent of Medicaid spending.<sup>5</sup> Despite this high level of spending, concerns persist with respect to the quality of care these individuals receive, their heightened risk for potentially preventable high-cost episodes of care, and the potential for unmet needs due to differences in the two public programs (Medicare and Medicaid) on which dual eligibles are highly dependent for care.

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<sup>1</sup> Under a 2009 contract with the Center for Health Care Strategies (CHCS), GW reviewed relevant statutory and regulatory authority for both the Medicare and Medicaid programs and analyzed legal barriers to the integration of Medicare and Medicaid funding to better enable states to coordinate the care for their dual eligible populations. GW addressed these barriers as well as a series of integrated model options in a final paper published by CHCS and the Commonwealth Fund, “Supporting Alternative Integrated Models for Dual Eligibles: A Legal Analysis of Current and Future Options.” This work was modified and incorporated in part for this background section.

<sup>2</sup> GRETCHEN JACOBSON, TRICIA NEUMAN, ANTHONY DAMICO & BARBARA LYONS., KAISER FAMILY FOUNDATION, THE ROLE OF MEDICARE FOR THE PEOPLE DUALY ELIGIBLE FOR MEDICARE AND MEDICAID (2011). Available at <http://www.kff.org/medicare/upload/8138.pdf>.

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*; THE KAISER COMMISSION ON MEDICAID FACTS: DUAL ELIGIBLES: MEDICAID’S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES (2011) Available at <http://www.kff.org/medicaid/upload/4091-08.pdf>.

<sup>5</sup> JACOBSON ET AL. *supra* note 2.

Care for dual eligibles is financed separately by the Medicare and Medicaid programs through a combination of fee-for-service models and managed care models. As a result, care delivery for this population is largely uncoordinated and fails to maximize the benefits and financial resources of both programs – often resulting in potentially avoidable high-cost episodes of care. To better enable coordinated care for dual eligibles, the Patient Protection and Affordable Care Act (ACA) created significant new opportunities. The ACA authorized the establishment of the Federal Office of Coordinated Health Care (referred to as the Medicare-Medicaid Coordination Office) and the Center for Medicare and Medicaid Innovation (Innovation Center) within CMS and granted these new bodies significant authority to test innovative payment models for Medicare and Medicaid and to improve coordination of care for dual eligibles.<sup>6</sup> The scope of their authority greatly expands CMS’ ability to design new payment and care delivery models for dual eligibles, including integrated models.

However, with the exception of the Program of All-inclusive Care for the Elderly (PACE), which is statutorily limited in scope,<sup>7</sup> options currently available to integrate care for dual eligible individuals create a sense of impermanence for CMS, states, and dual eligibles. States may seek approval for demonstrations through CMS’ Medicare-Medicaid Coordination Office and Innovation Center and, if successful, ultimately see them move beyond demonstration into full implementation in future years. At the same time, authorization for the current underpinning of the Medicare portion for existing integrated models, the Dual Eligible Special Needs Plans (SNP), has been subject to short-term authorizations, the most recent of which allows operation of SNPs only through the end of 2013. To permit plans to submit the required intent to operate in 2014, the SNP authority would need to be reauthorized prior to November, 2012.

This paper reviews barriers to clinical and financial integration in services for dual eligibles prior to passage of the ACA, identifies models used by states to integrate care through contract and waiver authorities available to CMS prior to passage of the ACA, describes two new demonstrations proposed by CMS through the Medicare-Medicaid Coordination Office and Innovation Center, and introduces a state plan option as a new model for consideration by federal and state policymakers. This new model draws on experience from existing programs and waivers to provide a permanent state plan option for a fully integrated, capitated care model that could be made available to states prior to the completion of the demonstration process begun by the Medicare-Medicaid Coordination Office and Innovation Center.

Authorization of a new state option for integrated care services would provide an additional pathway for states seeking to improve care management for dual eligibles, while providing a sense of permanence not currently available through demonstrations or through the existing SNP model. Such an approach would require new statutory authority under both Medicare and Medicaid, and could be borrowed from the structure used to authorize and implement PACE. This new state option would give states more flexibility in the near term, while at the same time

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<sup>6</sup> Patient Protection and Affordable Care Act of 2010, PUB. L. NO. 111-148, §§ 2602, 3021, 124 Stat. 119, 315, 389 (2010).

<sup>7</sup> For a more detailed discussion of the PACE program, see the discussion of existing models of care and Appendix B.

providing a more permanent structure overseen by CMS that assures high-quality, patient-centered care.

***Barriers to clinical and financial integration in health services for dual eligibles prior to the passage of the ACA***

Congress designed the Medicare and Medicaid programs to cover distinct populations, but the potential for overlap is significant in the case of elderly persons and persons with disabilities. A different title in the Social Security Act – Title XVIII and Title XIX respectively – governs each program. Distinct federal statutory provisions govern benefits and services, coverage standards, conditions of provider participation, provider payment, and methods of administration. No provision in either statute requires coordination between the federal and state government with respect to populations shared in common, even though arguably the individuals who are entitled to coverage under both programs are at greatest risk for chronic illness, disability, and death.

Statutory differences in the two programs are evident particularly with respect to determining coverage eligibility. Medicare uses a medical necessity standard for coverage and payment that defines coverage for items, treatments, and services that are “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” provided to a Medicare beneficiary.<sup>8</sup> This definition often fails to address the special needs of persons with chronic conditions, where the care may be focused on preventing deterioration and/or to maintaining functioning.<sup>9</sup> By contrast, federal Medicaid law accords states broad discretion to develop “reasonable” standards of medical necessity, subject only to a prohibition against discrimination based on condition in the provision of required coverage.<sup>10</sup>

The Medicare benefit includes medically necessary acute care services, such as hospital and physician services, hospice, skilled nursing facility (SNF), home health, durable medical equipment, and outpatient prescription drugs since 2006. Medicaid provides states with the option to cover services excluded from Medicare, such as long-term services in nursing facilities without the aggregate coverage limits applicable to Medicare,<sup>11</sup> home- and community-based care under waivers or as a state plan option,<sup>12</sup> personal care services,<sup>13</sup> dental care,<sup>14</sup> non-emergency medical transportation,<sup>15</sup> and eye care.<sup>16</sup> This has resulted in significant variation in

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<sup>8</sup> Social Security Act § 1863(1)(A), 42 U.S.C. § 1395z (2006).

<sup>9</sup> VICKI GOTTLICH, CENTER FOR MEDICARE ADVOCACY, MEDICAL NECESSITY DETERMINATIONS IN THE MEDICARE PROGRAM, ARE THE INTERESTS OF PERSONS WITH CHRONIC CONDITIONS BEING MET? (2003) *available at* [http://www.medicareadvocacy.org/News/Archives/chronic\\_JohnsHopkinsPaper\\_mednecessitydets.htm](http://www.medicareadvocacy.org/News/Archives/chronic_JohnsHopkinsPaper_mednecessitydets.htm).

<sup>10</sup> Social Security Act §§ 1902(a)(17), 1902(a)(30), 42 U.S.C. 1396a (2006); *see also* Services: General Provisions, 42 C.F.R. § 440.230 (2008).

<sup>11</sup> 42 U.S.C. § 1396d(a)(4) (2006).

<sup>12</sup> 42 U.S.C. § 1396d(a)(22) (2006).

<sup>13</sup> 42 U.S.C. § 1396d(a)(24) (2006).

<sup>14</sup> 42 U.S.C. § 1396d(a)(10) (2006).

<sup>15</sup> SARA ROSENBAUM, NANCY LOPEZ, MELANIE J. MORRIS & MARSHA SIMON, GEORGE WASHINGTON UNIVERSITY, SCHOOL OF PUBLIC HEALTH AND HEALTH POLICY, MEDICAID’S MEDICAL TRANSPORTATION ASSURANCE: ORIGINS, EVOLUTION, CURRENT TRENDS, AND IMPLICATIONS FOR HEALTH REFORM (2009) *available at*

coverage patterns across states. In addition, Medicaid provides coverage for the gaps in Medicare, such as the required cost-sharing for Medicare services or coverage for certain Medicare benefits that have been exhausted (e.g., inpatient hospital, SNF, and home health care).

The consequences of these differences can be considerable. Because federal Medicaid law allows states to pay for a wide range of treatments, benefits, and services excluded from Medicare, and to utilize a different group of providers, dual eligibles with long-term and chronic conditions may receive disjointed care. Costs averted from Medicare and absorbed by Medicaid may go unrecognized; conversely, Medicare providers may realize gains by quickly moving patients from Medicare treatment settings into settings whose costs are primarily borne by Medicaid. Patient care may lack stability and continuity because of the perverse incentives created by dual coverage under distinctly different programs that do not share a common provider cohort, benefit and service definitions, or methods of administration. Finally, states that cover only limited supplemental benefits for dual enrollees may have no financial incentive to strengthen coverage because they perceive that they bear the full cost exposure without the ability to realize cost offsets at least within the short term state budget cycle.

### *Existing models of care pre-ACA*

#### **Fee for Service and Managed Care**

The payment systems through which Medicare and Medicaid provide covered services to dual eligibles further strain the relationship between Medicare and Medicaid coverage. Prior to passage of the ACA, the Social Security Act only expressly authorized the HHS Secretary to make payments for Medicare-covered services to providers, suppliers, Part D plans, and Medicare Advantage (MA) plans.<sup>17</sup> The definitions of these terms did not include state Medicaid agencies. As such, the Secretary was not authorized to pay state Medicaid agencies for Medicare services unless they met the requirements of an authorized payment category (e.g., supplier, MA plans) or such payments were made under a demonstration or waiver authority.

Payment for Medicare services may be made through the Medicare Fee-For-Service (FFS) program or through a MA plan.<sup>18</sup> Reimbursement for Medicaid services may similarly be made on a FFS basis or through a contract with a participating managed care organization.<sup>19</sup> The vast majority of dual eligibles, more than 80%, receive care through Medicare FFS and stand-alone Medicare Prescription Drug Plans.<sup>20</sup> Since duals are exempt from mandatory managed care

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[http://gwumc.edu/sphhs/departments/healthpolicy/dhp\\_publications/pub\\_uploads/dhpPublication\\_377A5480-5056-9D20-3DF264AA41CFBDEC.pdf](http://gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_377A5480-5056-9D20-3DF264AA41CFBDEC.pdf).

<sup>16</sup> 42 U.S.C. § 1396d(a)(12) (2006).

<sup>17</sup> See, e.g., 42 U.S.C. § 1395w-28 (2006), 42 U.S.C. § 1395w-23 (2006), 42 U.S.C. § 1396b (2006), 42 U.S.C. § 1395g (2006).

<sup>18</sup> Formerly known as a Medicare +Choice plan. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 201(b), 42 U.S.C. § 1395w-21 (2010).

<sup>19</sup> Social Security Act § 1903m, 42 U.S.C. § 1396b (2006); Social Security Act § 1932, 42 U.S.C. § 1396u-2 (2006).

<sup>20</sup> CENTER FOR HEALTH CARE STRATEGIES, POLICY BRIEF: SUPPORTING INTEGRATED CARE FOR DUAL ELIGIBLES (2009) available at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=982564](http://www.chcs.org/publications3960/publications_show.htm?doc_id=982564).

enrollment requirements that states can impose under Medicaid,<sup>21</sup> little has been done to develop a strong cohort of integrated delivery systems certified under both Medicare and Medicaid and capable of furnishing comprehensive care to persons with serious and chronic illnesses and disabilities.

Over time, Congress has authorized some flexibility for Medicare and Medicaid to deliver services through mechanisms that foster greater care coordination, such as MA plans and SNPs as opposed to FFS. With few exceptions, such flexibility has been program specific and failed to foster cross-program coordination for dual eligibles. In fact, federal requirements still prohibit states from requiring dual eligibles to enroll in a managed care plan, either MA or Medicaid managed care without a waiver.<sup>22</sup> For further discussion of these programs, see Appendix A.

### **Program of All-Inclusive Care for the Elderly (PACE)**

The Balanced Budget Act of 1997 created a permanent authorization for the first and only federally qualified benefit to fully integrate all Medicare and Medicaid services for the frail elderly eligible for both programs. Based on a long-term demonstration program, PACE authorizes states to create and enroll their elderly dual eligibles in a coordinated care program funded through capitated or fixed payments from Medicare and Medicaid.<sup>23</sup>

PACE addresses the distinct requirements of the Medicare and Medicaid programs and overcomes the barrier to care coordination posed by differences between the two. For example, PACE regulations provide for a single set of requirements regarding eligibility, application procedures, administrative requirements, services, payment, participant rights, quality assurance, and marketing requirements.<sup>24</sup> These regulations allow a PACE organization to enter into an agreement with CMS and the state administering agency for the operation of a PACE organization.<sup>25</sup> Furthermore, a PACE organization may be an entity of a city, county, state, or tribal government or a private 501(c)(3) not-for-profit entity.<sup>26</sup> Critical to the integrated delivery and financing of the model are prospective monthly capitated payments from Medicare and Medicaid that are adjusted to take into account the frail nature of the PACE-eligible population.

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<sup>21</sup> Social Security Act § 1932, 42 U.S.C. § 1396u-2 (2006).

<sup>22</sup> *Id.*

<sup>23</sup> Balanced Budget Act of 1997 §§ 4801, 4802, 42 U.S.C. § 1395eee, 42 U.S.C. § 1396u-4.

<sup>24</sup> See PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). 42 C.F.R. Part 460 (codifying Administrative Requirements at Subpart E §§ 460.60 et seq., Marketing at § 460.82, Services at Subpart F §§ 460.90 et seq., Participant Rights at Subpart G §§ 460.110 et seq., Quality Assessment and Performance Improvement at Subpart H §§ 460.124 et seq., Participant Enrollment and Disenrollment at Subpart I §§ 460.150 et seq., Payment at Subpart J §§ 460.180 et seq., Federal/State Monitoring at Subpart K §§ 460.190 et seq., and Data Collection, Record Maintenance, and Reporting at Subpart L §§ 460.200 et seq.).

<sup>25</sup> 42 U.S.C. § 1396u-4(a)(4); 42 U.S.C. § 1395eee(a)(4); 42 C.F.R. §§ 460.10 et seq. (setting forth PACE organization application and waiver process); 42 C.F.R. § 460.30 (setting forth PACE program agreement requirements).

<sup>26</sup> 42 C.F.R. § 460.60 (explaining also that the 501(c)(3) entity may be a corporation, a subsidiary of a larger corporation, or a department of a corporation).

Despite evidence that PACE reduces costs for enrollees compared to Medicare FFS for the frail elderly population and comparable Medicaid beneficiaries, growth of PACE has been slower than expected.<sup>27</sup> Initially this growth was limited by the BBA, which only authorized 40 new programs in 1997 and 20 programs each year thereafter. Today, there are only 84 PACE programs operating in 30 states and while millions of dual eligible adults are potentially eligible, only 23,000 are enrolled.<sup>28</sup> This limited growth may be attributable to several factors including: 1) narrow eligibility requirements (e.g., eligible beneficiaries must be 55 or older, meet nursing facility level of care requirements, and live in a PACE organization service site);<sup>29</sup> 2) inability of non-profit PACE providers to raise sufficient capital to develop new sites or expand existing sites; 3) unwillingness of for-profit providers entering the market due to uncertainty over Medicare capitation rates; and 4) state level enrollment caps due to state budget shortfalls.<sup>30</sup> In addition, the requirement that the care management team include a physician may be a barrier for eligible individuals who do not want to change their primary care physician; others may not be interested in a model that requires them to travel to a congregate site for their care management. Finally, legal and financial disincentives also exist for state Medicaid programs to participate in PACE – it is optional and the savings generally tend to accrue to Medicare. For additional description of the PACE program, see Appendix B.

### **Demonstration and waiver authorities under sections 1115, 1915(a, b, and c), and 402**

The Secretary may waive certain federal requirements allowing state Medicaid programs to implement different payment models, cover more people, or – in the case of dual eligibles – more effectively coordinate care. Several demonstration and waiver options provide states additional flexibility to “waive” certain federal requirements, including Section 1115 waivers, Section 1915(a), (b), and (c) waivers, and Section 402/222 waivers. For example, states have used Section 1115 waiver authority to change their program in ways that would not otherwise be allowable under federal requirements (e.g., expanding coverage to new groups of people, modifying the delivery system, or changing the benefit package design). States have used 1915(b) waivers to implement mandatory enrollment in managed care plans for their Medicaid population. For additional description of these waiver and demonstration authorities, see Appendix C.

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<sup>27</sup> On average, costs for PACE enrollees are 16-38% lower than Medicare FFS costs for a frail elderly population and 5-15% lower than costs for comparable Medicaid beneficiaries. See TANAZ PETIGARA & GERARD ANDERSON, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HEALTH POLICY MONITOR: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY: SURVEY NO. 13 (2009) available at [http://www.hpm.org/de/Surveys/JHSPH\\_-\\_USA/13/Program\\_of\\_All-Inclusive\\_Care\\_for\\_the\\_Elderly.html;jsessionid=EF6A66025A10BB0AB80B56888F8F0CE9?content\\_id=251&sortBy=sortCountry&sortOrder=sortAsc&lastSortBy=sortCountry&lastSortOrder=sortAsc&language=de&pageOffset=85](http://www.hpm.org/de/Surveys/JHSPH_-_USA/13/Program_of_All-Inclusive_Care_for_the_Elderly.html;jsessionid=EF6A66025A10BB0AB80B56888F8F0CE9?content_id=251&sortBy=sortCountry&sortOrder=sortAsc&lastSortBy=sortCountry&lastSortOrder=sortAsc&language=de&pageOffset=85).

<sup>28</sup> National PACE Association, PACE in the States, available at <http://www.npaonline.org/website/download.asp?id=1741>.

<sup>29</sup> Participant Enrollment and Disenrollment, 42 C.F.R. § 460.150(b) (2008).

<sup>30</sup> PETIGARA & ANDERSON, *supra* note 27.

### Existing state models for dual eligibles

States have used a variety of waiver and demonstration authorities and PACE options to achieve more flexibility in their care for dual eligibles. For example, Minnesota, Wisconsin and Massachusetts have used waivers to achieve more flexibility in their care for dual eligibles as part of dual eligible demonstration programs. The State of Minnesota operated its program under Sections 1915(a)/1915(c) and 1115 waiver authority.<sup>31</sup> Wisconsin operated under a Section 1115 waiver and later switched to a 1915(c) waiver.<sup>32</sup> Massachusetts operated its dual eligible demonstration using authority under its Medicaid state plan and Section 1915(a). All three used 402/222 for Medicare payment waivers. Through the waivers and related agreements, CMS, the state, and the health plans addressed: 1) the use of a uniform set of requirements to enable the health organization to provide a seamless Medicare/Medicaid product to dual eligible beneficiaries; 2) the use of additional administrative funds and/or services as required; 3) coordination of the review of marketing materials, contract oversight and on-site reviews; and 4) who (health plan or state Medicaid agency) is responsible for member education and determining beneficiaries' disenrollment rights.<sup>33</sup> Once the demonstration ended on December 31, 2007, the managed care contractors involved with these programs transitioned to SNP status and authority.<sup>34</sup>

The Arizona Medicaid program operates the Arizona Health Care Cost Containment System (AHCCS), a mandatory managed care program created under a Section 1115 Research and Demonstration Waiver. Four of its Medicaid managed care contractors operate as SNPs.<sup>35</sup> The SNPs may passively enroll any dual eligible into its Medicare managed care plan if the individual had already enrolled with the organization under a Medicaid managed care plan.<sup>36</sup> Additionally, for individuals that qualify for long-term care, Arizona also offers the Arizona Long-Term Care System (ALTCS) through AHCCS.<sup>37</sup> ALTCS does not fully integrate Medicare and Medicaid; beneficiaries are not required to receive benefits from each program through the same plan. Rather, the state requires that managed care plans either become a SNP, or establish a partnership with a MA plan or SNP, through which a dual eligible may receive

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<sup>31</sup> CENTERS FOR MEDICARE & MEDICAID SERVICES, LONG-TERM CARE CAPITATION MODELS: A DESCRIPTION OF AVAILABLE PROGRAM AUTHORITIES AND SEVERAL PROGRAM EXAMPLES 16-19 (2007) *available at* [https://www.cms.gov/IntegratedCareInt/2\\_Integrated\\_Care\\_Roadmap.asp](https://www.cms.gov/IntegratedCareInt/2_Integrated_Care_Roadmap.asp) [hereinafter "CAPITATION MODELS"].

<sup>32</sup> *Id.* at 19-21; *see also* Centers for Medicare and Medicaid Services, *Medicaid Waiver and Demonstration List, Wisconsin*, <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/List.asp> (last visited Oct. 27, 2011).

<sup>33</sup> CAPITATION MODELS *supra* note 31 at 21-23.

<sup>34</sup> PAUL SAUCIER & BRIAN BURWELL, THE IMPACT OF MEDICARE SPECIAL NEEDS PLANS ON STATE PROCUREMENT STRATEGIES FOR DUALY ELIGIBLE BENEFICIARIES IN LONG-TERM CARE 3 (2007) *available at* <http://muskie.usm.maine.edu/Publications/MedicareSNP.pdf>; *see also* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO CONGRESS: UPDATE ON THE MEDICARE ADVANTAGE PROGRAM 263 (2008) *available at* [http://www.medpac.gov/chapters/Mar08\\_Ch03.pdf](http://www.medpac.gov/chapters/Mar08_Ch03.pdf).

<sup>35</sup> KAREN TRITZ, CRS REPORT FOR CONGRESS, INTEGRATING MEDICARE AND MEDICAID SERVICES THROUGH MANAGED CARE (2006).

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*



Medicare services and receive improved care coordination.<sup>38</sup> However, beneficiaries do not have to accept the companion SNP, but rather may choose an entirely different SNP. Eight different managed care plans were designated to provide ALTCS services in 2006.<sup>39</sup>

The state of New York also provides a good example of a multi-program approach. Currently, New York runs three separate, but coordinated managed care plan models to address the needs of dual eligibles. All three programs are voluntary. The first of these, Medicaid Advantage, requires dually eligible adults that participate in the program to enroll in a plan that is approved as both a Medicare SNP and a Medicaid managed care plan.<sup>40</sup> As of 2009, Medicaid Advantage contracted with 11 SNPs in 27 counties and New York City to cover 5,413 members. Medicaid Advantage does not provide long-term care;<sup>41</sup> it was designed to allow Medicaid enrollees who become eligible for Medicare to retain their enrollment in Medicaid managed care.

The second program is Medicaid Advantage Plus (MAP). To qualify for MAP, dual eligible enrollees must have long-term care needs and meet state criteria to receive nursing home services.<sup>42</sup> Dual eligibles that participate must enroll in a Medicare SNP before enrolling in the MAP. The Medicare SNP contracts with the state to provide the full range of covered primary, acute and long-term care services.<sup>43</sup> MAP is an alternative to a Medicaid Long Term Care Plan, which provides Medicaid services only. As of 2009, New York had contracted with four Medicare SNPs in five counties and New York City, covering only 421 beneficiaries in MAP plans.

Finally, New York offers a PACE program to provide comprehensive health care for qualifying individuals age 55 and older.<sup>44</sup> Enrollment is voluntary, and both Medicare and Medicaid pay for services on a capitated basis. Beneficiaries must use doctors within the PACE network, but the physicians are responsible for providing or arranging for all primary, inpatient and long-term care services the member may need.<sup>45</sup> There are five PACE sites throughout New York, each with a separate contract with the New York State Department of Health.<sup>46</sup> See Appendix D for more information on state-specific models.

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<sup>38</sup> BRIAN BURWELL, PAUL SAUCIER & LINA WALKER, AARP PUBLIC POLICY INSTITUTE, CARE MANAGEMENT PRACTICES IN INTEGRATED CARE MODELS FOR DUAL ELIGIBLES (2010) available at <http://assets.aarp.org/rgcenter/ppi/health-care/health-dual0910.pdf>.

<sup>39</sup> TRITZ, *supra* note 35.

<sup>40</sup> BARBARA COULTER EDWARDS, ET AL., AARP PUBLIC POLICY INSTITUTE, INTEGRATING MEDICARE AND MEDICAID: STATE EXPERIENCE WITH DUAL ELIGIBLE MEDICARE ADVANTAGE SPECIAL NEEDS PLANS (2009) available at [http://assets.aarp.org/rgcenter/ppi/health-care/2009\\_14\\_maplans.pdf](http://assets.aarp.org/rgcenter/ppi/health-care/2009_14_maplans.pdf).

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> David Kronenberg & David Silva, *Medicaid Managed Long Term Care in New York Part I*, ELDER L. ATT'Y, Winter 2010, at 10.

<sup>45</sup> *Id.* at 11.

<sup>46</sup> *Id.* at 13.



## **II. OVERVIEW OF CHANGES IN ACA AND RECENT AGENCY ACTION**

Despite various waivers, demonstrations programs, and PACE options described above and in the Appendices, CMS and states still struggle to deliver care to dual eligibles in a coordinated manner. The costs to both programs have continued to increase. The limitations and barriers inherent in the use of two separate programs as well as time-limited waivers and demonstrations have not met the needs of the dual eligible population or supported coordinated, efficient, and cost-effective care delivery systems. Congress took significant steps to address these concerns and put in place a new infrastructure to develop and implement programs that will result in higher-quality, lower-cost care for dual eligibles.

### ***The Medicare-Medicaid Coordination Office***

The ACA directed the Secretary to establish the Medicare-Medicaid Coordination Office (referred to as the Federal Coordinated Health Care Office in the actual legislation) within CMS. The purpose of the new office is to integrate benefits under the Medicare and Medicaid programs and to better coordinate care for dual eligible individuals. The law's stated goals include assuring that duals receive access to benefits covered under each program, easing access to services, assisting duals in better understanding coverage, and improving their satisfaction.

The ACA charges the Medicare-Medicaid Coordination Office with eliminating regulatory conflicts between the two programs that impede continuity of care. In addition, the ACA directs the Coordination Office to improve quality of care and to eliminate cost-shifting between the programs. Additional responsibilities include assisting states, SNPs, and providers with benefit alignment, supporting state efforts to coordinate and align acute and long-term care services, providing support for coordination of contracting and oversight by CMS, consulting with MedPAC and the Medicaid and CHIP Payment and Access Commission (MACPAC), and studying prescription drug coverage for new full-benefit dual eligibles.<sup>47</sup>

### ***Center for Medicare and Medicaid Innovation***

The ACA also established a new Center for Medicare and Medicaid Innovation (Innovation Center) within CMS to test innovative payment and service delivery models with a goal of improving quality and reducing costs under the Medicare and Medicaid programs.<sup>48</sup> The law outlines a series of initiatives, from which the Secretary may choose, to improve the quality and efficiency of delivery of health care services. Among the initiatives are those permitting the Secretary, in conjunction with states, to test and evaluate models to fully integrate care for dual eligibles, as well as other models to improve care coordination. The Secretary may waive any Medicare requirement and Medicaid requirements relating to statewideness, payments, and actuarial soundness for Medicaid managed care plans to implement such service delivery models. Further, the Secretary may expand any model of care determined to reduce spending without reducing quality of care, or any model determined to improve quality without increasing

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<sup>47</sup> ACA § 2602.

<sup>48</sup> ACA §3021(a)..

spending.<sup>49</sup> The Secretary may combine waiver authority under this section with existing waiver authority granted under Sections 1915 and 1115 of the Social Security Act (described above).

The ACA also authorizes reimbursement for new delivery models in Medicare or Medicaid including the testing of accountable care organizations (ACOs), medical and health homes, and provisions affecting state waivers under Medicaid. CMS has taken considerable action to implement these and other initiatives. For more information regarding ACA changes affecting dual eligible individuals, see Appendix E.

### ***Alignment Initiative***

CMS issued a Request for Information (RFI), on ways to better “align benefits and incentives to prevent cost-shifting and improve access to care” for dual eligible individuals.<sup>50</sup> The RFI states that, consistent with the Alignment Initiative,<sup>51</sup> the Medicare-Medicaid Coordination Office is working to identify conflicting requirements that create barriers to “high-quality, seamless and cost-effective care.” The RFI seeks comments on a list of regulatory and legislative initiatives.<sup>52</sup> The Medicare-Medicaid Coordination Office identified six areas where conflicting requirements pose a barrier to coordination: coordinated care, fee-for-service benefits, prescription drugs, cost-sharing, enrollment, and appeals.

### ***State Medicaid Director Letter***

In July 2011, CMS issued a State Medicaid Director (SMD) letter announcing that Innovation Center, in concert with the Medicare-Medicaid Coordination Office, will test two financial alignment models designed to fully integrate delivery system and care coordination for dual eligibles.<sup>53</sup> Thirty-eight states have indicated intent to participate.<sup>54</sup> Under the terms of the SMD letter, participating states may use a fully-capitated model, a managed fee-for-service model, or a combination of the two.<sup>55</sup> The following section summarizes key issues identified in the July SMD letter.

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<sup>49</sup> *Id.*

<sup>50</sup> Request for Information, Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare. 76 FED. REG. 28196 (May 16, 2011).

<sup>51</sup> Exec. Order No. 13,563, 76 Fed. Reg. 3821 (Jan. 18, 2011).

<sup>52</sup> *RFI* at 28198, *supra* note 50.

<sup>53</sup> CENTERS FOR MEDICARE & MEDICAID SERVICES, SMDL #11-008, FINANCIAL MODELS TO SUPPORT STATE EFFORTS TO INTEGRATE CARE FOR MEDICARE-MEDICAID ENROLLEES (2011) [hereinafter “SMDL #11-008”].

<sup>54</sup> Centers for Medicare & Medicaid Services. States Submitting Letters of Intent-Financial Alignment Models, available at <https://www.cms.gov/medicare-medicare-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf>.

<sup>55</sup> SMDL #11-008 *supra* note 53.

### **Full Capitation**

Under the fully-capitated model, CMS, states, and health plans will enter into three-party contracts to provide coverage for full-benefit dual eligibles.<sup>56</sup> Plans eligible to enter into contracts include MA plans, Medicaid managed care plans, or other plans able to meet standards established jointly by states and the federal government.<sup>57</sup> CMS indicated that payment rates would be based on an actuarially-developed blended rate, which would result in aggregate savings.<sup>58</sup> Plans will be selected through “competitive joint procurement” and required to meet quality measures and beneficiary protections specified in the three-party contracts.<sup>59</sup>

CMS indicated that the demonstrations will test “administrative, benefit, and enrollment flexibilities,” and may include supplemental benefits, enrollment flexibility, and single appeals processes, single auditing, and single marketing rules and procedures for Medicare and Medicaid services. A state that signs a letter of intent to implement one of the models will work with CMS to meet standards and conditions of demonstration and will sign a Memorandum of Understanding (MOU) with CMS. CMS and states will develop and release procurement documents, select from among qualified plans, conduct readiness reviews, and sign contracts.<sup>60</sup> Once implemented, CMS and states will jointly monitor plans for compliance.<sup>61</sup>

Under the terms of the draft MOU released with the SMD letter, additional guidance provided by CMS will determine much of the structure of the capitated model.

### **Managed Fee-for-Service**

The SMD letter also included a MOU for providers or networks of providers to integrate care for dual eligibles through a fee-for-service arrangement. Under this model, CMS envisions the use of existing state structures of care as well as new models authorized under the ACA, including ACOs and medical homes, and health homes.<sup>62</sup> CMS will test a retrospective performance payment to states based on Medicare savings achieved for dual eligible enrollees.<sup>63</sup> As in the capitated model, the state must assure seamless integration of all medically necessary services, including behavioral health and long-term care services and supports.<sup>64</sup> States will finance upfront investment in care coordination networks, and will be eligible for performance payments if the state reaches a target level of savings (as certified by the Office of the Actuary) to Medicare.<sup>65</sup> CMS will make payments to states net of any federal increase in Medicaid

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<sup>56</sup> *Id.* at 4.

<sup>57</sup> *Id.* at 2.

<sup>58</sup> Centers for Medicare & Medicaid Services, Draft Template MOU for Capitated Model 7 (2011) [hereinafter “DRAFT MOU”].

<sup>59</sup> *Id.* at 5.

<sup>60</sup> SMDL #11-008 *supra* note 53 at 6.

<sup>61</sup> *Id.* at 6-7; DRAFT MOU *supra* note 59 at 6.

<sup>62</sup> SMDL #11-008 *supra* note 53 at 5

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*, DRAFT MOU *supra* note 59 at 4.

<sup>65</sup> SMDL #11-008 *supra* note 53 at 5.

expenditures.<sup>66</sup> In addition to savings targets, payments will be contingent upon states meeting or exceeding certain quality thresholds.<sup>67</sup> CMS will provide standards through supplemental guidance to ensure consistency across states, sound management and beneficiary protections.

### III. ANALYSIS OF CURRENT POLITICAL AND POLICY CONSIDERATIONS

The ACA, through the Innovation Center, provides unprecedented authority to the Secretary to waive provisions of Medicare law, as well as Medicaid statewideness requirements. When combined with the authority available under section 1115 of the Social Security Act to waive Medicaid requirements, this flexibility can lead to the development of models of care that have the potential to transform the delivery of health and long-term support services to dual eligible individuals.

While policy experts have suggested guidelines for successful care models, there is not a preferred model of integrated care for dual eligible individuals, given the diverse needs of dual eligible individuals. A recent report by the Medicare Payment Advisory Commission (MedPAC), asserts that no single model will work in every state and a “lack of comparable outcomes research... leaves open the question of which models are most effective.”<sup>68</sup> Experts suggest key elements include strong patient-centered primary care; multi-disciplinary care teams capable of addressing medical, behavioral and social needs; a comprehensive provider network; robust data-sharing and communication systems; consumer protections to ensure access to community-based providers and consumer involvement in program design and governance; and financial alignment.<sup>69</sup> Collectively, ACA provisions affecting dual eligible individuals reflect a measured approach to addressing the needs of beneficiaries through improving care integration, as well as the needs of state and federal policy makers for increased financial accountability and efficiency in the delivery of services.

Testing and implementation of these models requires a delicate balance between providing states and providers with the financial incentives and flexibility to make care more cost-effective, and important quality standards and beneficiary protections to guarantee access and improved quality. Expansion of demonstrations and the ultimate success of efforts to integrate care for dual eligibles under the terms of the statute will require both. As noted in the previous section, CMS’ efforts to implement integrated care for dual eligible individuals are proceeding on multiple tracks. CMS has issued informal guidance, including the announcement of technical assistance grants to 15 states as well as the SMD letter. The agency has also issued a request for information for public comment on major barriers to integration that CMS will presumably use to inform decisions as state demonstrations move forward.

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<sup>66</sup> *Id.*, DRAFT MOU *supra* note 59 at 4.

<sup>67</sup> *Id.*

<sup>68</sup> MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM. 125 (2011) [hereinafter “JUNE 2011 MEDPAC REPORT”].

<sup>69</sup> MELANIE BELLA & LINDSAY PALMER, CENTER FOR HEALTH CARE STRATEGIES, INC, ENCOURAGING INTEGRATED CARE FOR DUAL ELIGIBLES 12 (2009) *available at* [www.chcs.org/usr\\_doc/Integrated\\_Care\\_Resource\\_Paper.pdf](http://www.chcs.org/usr_doc/Integrated_Care_Resource_Paper.pdf).

## *Temporary Models*

Although the ACA took a measured approach to the integration of care for dual eligibles, in the 18 months since enactment of the ACA, states face increasing pressure to address budget deficits. While states are beginning to recover from the effects of the recent recession, they must address very large budget shortfalls, and will continue to struggle to find revenue to support public services, including state expenditures for health care services, such as Medicaid.<sup>70</sup> Although analysts differ as to the impact of the ACA on state Medicaid expenditures, states will certainly see some increase in costs associated with the expansion of coverage under the ACA.<sup>71</sup> Provisions of the ACA prevent states from reducing Medicaid eligibility prior to January 1, 2014, except for certain populations with incomes over 133 percent of Federal Poverty Level (FPL), and only if the state certifies that the state is projected to have a budget deficit.<sup>72</sup> In light of these financial pressures, states are seeking options to move quickly to integrate Medicare and Medicaid services as a means of lowering Medicaid expenditures.

The two new demonstration models proposed in the July 2011 SMD letter provide states with significant new opportunities and flexibility to develop and implement integrated programs for dual eligibles, however the programs are authorized for a period of no more than three years. While 38 states have indicated intent to participate in the demonstration, policymakers have raised concerns as to whether the temporary nature of the demonstrations may limit the development of effective longer-term sustainability strategies, and that the existing process may take years to realize long-term results.<sup>73</sup> Critical to the success of these programs, particularly those based on a capitated model will be the development of provider networks and effective resources for care management across providers. These relationships and processes often take years to develop, but once forged can be incredibly successful. It is unclear whether CMS will consider extending the demonstrations beyond three years, but states, providers and health plans should be encouraged to think beyond the three year timeline of the CMS demonstrations and design programs focusing on long-term continuity and sustainability for this vulnerable population. To do otherwise, could well result in the same uncertainties that plagued the implementation of SNPs.

## *Review Cycle*

In the July SMD letter, CMS notes that all the demonstrations will include a “rigorous evaluation.” However, it is unclear whether CMS can effectively accomplish this evaluation given the short duration of the demonstrations and the need for interested states to be ready to implement by the end of 2012. Furthermore, it is unclear given the timing of CMS consideration of health plan bids for MA, whether interested plans may be ready by the end of 2012. Finally,

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<sup>70</sup> ELIZABETH MCNICHOL, PHIL OLIFF, & NICHOLAS JOHNSON, CENTER ON BUDGET AND POLICY PRIORITIES, STATES CONTINUE TO FEEL RECESSION’S IMPACT (2011) available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=711>.

<sup>71</sup> JOHN HOLAHAN & STAN DORN, URBAN INSTITUTE, WHAT IS THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON THE STATES (2010) available at <http://www.urban.org/publications/412117.html>.

<sup>72</sup> ACA §2001.

<sup>73</sup> *Dually-Eligible Beneficiaries: Improving Care While Lowering Cost, Hearing Before the S. Comm. on Finance*, 112<sup>th</sup> Cong. (2011).

given the structure of the demonstration authority available to CMS under the Innovation Center, the agency will not have the authority to expand these programs beyond the demonstration stage until at least 2015, assuming the current models tested will be successful. If CMS is forced to restructure the models, and test them again, expansion to a national scale will be even further away.

### ***Interaction with SNPs***

Another issue for consideration is how the proposed models in the July SMD letter will interact with current SNPs and SNP arrangements. Will current SNP arrangements be grandfathered in to participate as the (or one of several) managed care plan(s) in the capitated model? Will existing contractual arrangements between the Medicare program and SNPs be amenable to incorporation into a three-way arrangement with state Medicaid agencies? If not, what role might they or should they play? Those SNPs that are already contracting with Medicare and state Medicaid agencies are best positioned to transition to the new models contemplated by the demonstration, but those that are not may be able to more quickly transition to the new models than they would to forming a brand new SNP.

### ***Role of PACE***

The PACE model provides a solid example of a permanent program that has successfully integrated Medicare and Medicaid care delivery and financing for eligible individuals. Unlike SNPs, which are a subset of the MA program, oversight and programmatic direction for PACE resides operationally under Medicaid at CMS. This may allow PACE sites to better align with other state initiatives such as home and community-based services waivers for dual eligibles and non-duals. Furthermore, PACE contracting cycles are also flexible and set by the state; not the MA calendar which again allows for better alignment with related state initiatives as well as the state budget cycle.

While PACE is currently statutorily limited to people 55 years or better eligible for an institutional level of care (and in practice to those who are willing to change primary care providers and receive many services in a group setting), Congress could modify this and related requirements to expand the scope of PACE programs to include a broader duals population. However, the modifications needed to bring PACE to a scale that would make a difference would so fundamentally change the model that there is risk of losing its inherent culture and respected place in the policy landscape.<sup>74</sup>

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<sup>74</sup> For example, Congress would have to amend 42 U.S.C. §§ 1395eee(a)(5) and 1396u-4(a)(5) by removing subparagraphs (A) and (B) relating to age and level of care requirements. Moreover, clause (i) in 42 U.S.C. §§ 1395eee(f)(2)(B)(i) and 1396u-4(f)(2)(B)(i) prevents the Secretary from modifying or waiving the provisions of the PACE protocol that require a focus on frail elderly individuals who require the level of care provided in a nursing facility. Because these provisions would not be applicable if Congress removed the age and level of care requirements, clause (i) would require a conforming change in both sections. Likewise, subparagraph (A) in 42 U.S.C. §§ 1395eee(c)(3)(A) and 1396u-4(c)(3)(A) and paragraph (4) in 42 U.S.C. §§ 1395eee(c)(4) and 1396u-4(c)(4) require annual reevaluation of the nursing-facility level of care and allow continued eligibility for certain individuals who do not meet the nursing-facility level of care. Were the level of care requirement removed, a conforming change to subparagraph (A) and paragraph (4) would also be necessary in both sections.

Short of the necessary legislative changes to expand PACE to a broader group of dual eligibles, PACE sites can and should continue to operate in their current form alongside the new permanent state plan option (discussed in more detail below) and certainly in tandem with either the new capitated or managed FFS models proposed in the July SMD letter. PACE sites are being developed in many states, including New York as described above and a PACE site being developed by CalOptima, a county organized health system serving over 384,000 Medicaid lives and 12,800 duals.<sup>75</sup> Several of the selected CMS demonstration states are pursuing PACE as part of their strategy for duals and the National PACE Association is actively working with the Medicare-Medicaid Coordination Office.

#### ***IV. NEW PERMANENT STATE PLAN OPTION***

While the July SMD letter and options for new integrated care model demonstrations provide a significant opportunity to continue to test different integrated models for dual eligibles, as noted above, the temporary nature of the demonstrations may limit states ability to move forward on a broader scale in the short-term. Several states have already conducted demonstrations or tested new models using various waiver authorities that have shown successful outcomes from integrated financial and care delivery models; however when some of these demonstrations transitioned to the SNP model they lost some of the integrated approaches. Building on the steps taken through the ACA, Congress could pass legislation authorizing a new permanent program drawing from the administrative framework of PACE that would allow those states that are ready to proceed with long-term planning and implementation of a permanent model for their dual eligible populations to do so. The enactment of legislation to permit a new state plan option under Medicaid for dual eligibles is consistent with the demonstrations conducted under the framework of the July SMD letter. These demonstrations will inform state and federal policymakers who seek to implement the new state plan option. The permanence of a new program would simply permit states that are ready, to move forward without the limitations inherent in time-limited demonstrations.

For purposes of this paper, this new alternative program will be called the new state plan option. In general, it would be a permanent program structured with its own identity as an integrated program similar to PACE utilizing a Medicaid state plan option initiated by the state and managed by states similar to other forms of Medicaid managed care. Medicare dollars and coverage would be addressed through a three-way agreement between CMS, a state, and participating health plans. The lead by the state distinguishes this model from the Office of Medicare-Medicaid Coordination's proposed demonstrations which imply a more active operational engagement by the federal government. Elements of the new model are described in further detail below.

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<sup>75</sup> Information provided by Association for Community Affiliated Plans.



### *Establishing a New Structure - State and Federal Roles*

The states and the federal government would act as partners in establishing the framework of a new state plan option to improve quality and efficiency of care provided to dual eligible individuals. Federal requirements developed for MA plans and applied to SNPs, have failed to fully reflect the differences between Medicare and Medicaid and the needs of dual eligible beneficiaries.

While the magnitude of federal dollars at risk in Medicare and the federal share of Medicaid spending, among other factors, necessitate federal involvement in the development and oversight of the new option to assure strong beneficiary protections and fiscal integrity under a new state plan option, states would take the lead in procurement of services from qualified plans and ongoing contract management and quality within the federal framework. States are uniquely experienced in the provision of long-term care services and supports, as well as behavioral health benefits and services, which often are more robust under Medicaid than Medicare. States also are responsible for assuring that plans have adequate network capacity for those services, better understand local markets, and have experience in contracting with plans to provide services to Medicaid-eligible individuals. States choosing to participate in the new state plan option would select and contract with plans that meet minimum federal standards established in statute and clarified through regulations to provide integrated care services for dual eligible individuals.

The Medicare-Medicaid Coordination Office, with technical assistance from both the Center for Medicare Services and the Center for Medicaid and CHIP Services, would administer the new state option in order to assure a less “Medicare-centric” approach to the provision of care for dual eligibles, adequate oversight for purposes of protecting beneficiaries, and the integrity of federal dollars. States would be permitted to impose additional standards, such as state licensure and other requirements.

CMS, acting through the Medicare-Medicaid Coordination Office, and working in conjunction with state Medicaid programs, would issue guidance regarding eligibility as a participating plan, application procedures for federal certification, minimum covered services, reimbursement, minimum internal and external appeals, beneficiary protections, network adequacy standards, quality assurance, marketing guidelines, and other requirements. In establishing guidance, the Medicare-Medicaid Coordination Office would establish flexible timelines that coincide with state budget cycles. CMS and participating states would have joint authority to oversee plans, impose sanctions, conduct enforcement actions, and terminate plan certification at the state or federal level as applicable. CMS would have the authority to suspend enrollment, suspend Medicare payment to the organizations, or deny payment to the state for medical assistance for services furnished under the program agreement. States would have the authority to impose similar sanctions for violations of state requirements. Both states and the federal government would have the authority to impose civil money penalties up to a set amount for each violation.

As is the case with PACE, the new state option would be treated as a separate program with a single set of requirements regarding eligibility, application procedures, administrative

requirements, services, payment, participant rights, quality assurance, and marketing requirements.

### ***Eligibility***

All full-benefit dual-eligibles would be eligible for the full range of medically necessary Medicare and Medicaid services under the State plan , as well as care coordination and non medical benefits offered through a health plan as part of home and community based long-term care supports and services. In addition, many low-income Medicare-only beneficiaries have chronic conditions, and without care coordination services will continue to see a decline in health or functional status.

At state option, plans could also cover care coordination services for low-income Medicare-only beneficiaries with chronic conditions to help prevent or delay deterioration in health or functional status. CMS could waive the state responsibility for cost sharing for partial duals that receive care coordination from the plan in conjunction with their Medicare benefits, so long as states certify to the Secretary that there will be no increase in beneficiary out-of-pocket costs.

Stability of eligibility is crucial to integrated care efforts. Under current law, states have the option of making low-income children and pregnant women eligible for a period of 12 months, regardless of fluctuations in monthly income, which would result in individuals moving on and off Medicaid over the course of a plan year. A similar option is not available for Medicaid eligible individuals who are elderly or disabled. Individuals' dropping on and off Medicaid coverage results in a discontinuity in medical care and is detrimental to patient care. This is especially detrimental given the increasing pressures on the availability of Medicaid participating providers as CMS and states implement the ACA Medicaid expansions.<sup>76</sup> The new state plan option would provide authority and require participating states to adopt 1-year of continuous eligibility for dual-eligible beneficiaries.

### ***Benefits***

Under a new state plan option, participating plans would be required to cover all Medicare benefits, as well as all Medicaid benefits offered under a Medicaid plan and related home- and community-based services waivers. In addition, plans would be required to offer coordination services and would be permitted to offer additional supplemental benefits, to the extent that there are quantifiable savings associated in either Medicare or Medicaid spending relative to the existing baseline.

Although both the Medicare and Medicaid programs define benefits that must be covered, or in the case of Medicaid, mandatory benefits that must be provided by states and optional benefits that may be covered by states, both programs require benefits to be "medically necessary." Critical to the availability of covered benefits is the definition of medical necessity. Limiting

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<sup>76</sup> THE KAISER COMMISSION ON THE UNINSURED, ENSURING ACCESS TO CARE IN MEDICAID UNDER HEALTH REFORM (2011) Available at <http://www.kff.org/healthreform/8187.cfm>.

benefits to those covered items and medically necessary services permits benefit administrators (public and private) to restrict the availability of covered services. For example, limiting medical necessity to items and services to the “treatment of illness, injury, disease condition,” can allow benefit administrators to limit coverage of conditions that were present at birth.<sup>77</sup>

At the same time, a medical necessity requirement assures that individuals do not receive services for which there is no clinical justification. Medical necessity standards, however, are not always the most appropriate determining factor in the provision of certain Medicaid services, particularly for the provision of community based services and supports. For example, under the state Medicaid personal care option, persons with disabilities are assessed and services are provided based on a need for assistance with activities of daily living and instrumental activities of daily living.<sup>78</sup>

As discussed above, the Medicare standard does not adequately address the needs of individuals with chronic conditions because courts have interpreted the language as limiting coverage to items and services designed to improve or cure conditions.<sup>79</sup> Given the diverse needs of dual-eligible individuals, as well as the historical use of a medical necessity standard to limit the availability of services for persons with chronic conditions, the definition of medical necessity under the new state plan option should be carefully written to assure that individuals with chronic conditions and disabilities have access to services, and that, as under current Medicaid law, discrimination is not permitted based on condition.<sup>80</sup>

Advocates have suggested the medical necessity definition used by the North Carolina Division of Medical Assistance as a model:

Medically necessary services - Those services which are in the opinion of the treating physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage, may not arbitrarily be denied or reduced solely

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<sup>77</sup> For more discussion regarding benefit design, see SARA ROSENBAUM, JOEL TEITELBAUM, AND KATHERINE HAYES, THE ESSENTIAL HEALTH BENEFITS PROVISIONS OF THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PEOPLE WITH DISABILITIES. Commonwealth Fund, March 2011.

<sup>78</sup> GARY SMITH, JANET O’KEEF, LETTY CARPENTER, PAMELA DOTY & GAVIN KENNEDY, ” U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES: A PRIMER 42 (2000) available at <http://aspe.hhs.gov/daltcp/reports/primer.pdf>.

<sup>79</sup> It should be noted, however, that in 2010, two federal district courts held that Medicare’s medical necessity standard should not be interpreted to limit coverage to benefits that improve conditions, and has required Medicare to cover skilled nursing facility care when it prevents deterioration of a condition. See *Anderson v. Sebelius*, (D. Vt., filed Oct. 25, 2010). See also *Papciac v. Sebelius* 742 F. Supp. 2d, 765 (W.D. PA 2010).

<sup>80</sup> Social Security Act §§ 1902(a)(17), 1902(a)(30), 42 U.S.C. 1396a (2006); see also Services: General Provisions, 42 C.F.R. § 440.230 (2008).

because of the diagnosis, type of illness, or condition (42 CFR 440.230). Medicaid EPSDT coverage rules (42 USC §1396(r)(5) and 42 USC §1396 d(a)).<sup>81</sup>

### ***Enrollment***

While most health policy experts and consumer advocates agree that dual eligible individuals will benefit from an integrated system of care, there is considerable debate over the appropriate means to enroll duals in care coordination programs. While evidence shows that fully integrated care plans can reduce or eliminate the fragmented system of care for dual eligibles, enrollment remains low in the majority of programs, at least in part, because enrollment is voluntary.<sup>82</sup>

Voluntary enrollment, according to some plans, results in low enrollment, making it impractical for states or plans to invest in the staff needed to support care coordination programs.<sup>83</sup> Conversely, consumer advocates consider choice an integral part of consumer protection. Dual eligibles, they assert, must retain the right to choose whether to enroll in a care coordination model, to assure that beneficiaries continue to have access to specialists and other providers that may not participate in integrated models of care.<sup>84</sup>

While some policymakers would argue that Medicare beneficiaries, generally, should be enrolled in capitated programs as a condition of receipt of services in Medicare,<sup>85</sup> opposition by consumer advocates, the potential for disruption in care for frail elderly, disabled or chronically ill individuals, and accompanying media reports, makes this approach unlikely. Generally, discussions related to enrollment of dual eligibles in capitated coordinated care programs center on either voluntary enrollment (opt-in) or passive enrollment (auto-enrollment with opt-out). In the SMD letter, CMS adopts a passive enrollment process that provides the opportunity for beneficiaries to make “voluntary choice to enroll or disenroll from participating plans at any time.”<sup>86</sup>

To assure adequate volume of dual eligible enrollees and to ensure that dual eligible individuals are in a coordinated system as their health conditions change, the state plan option would utilize,

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<sup>81</sup> National Health Law Program, Model Medicaid Managed Care Contract Provisions. In addition NHeLP includes a more detailed definition, which should also be given careful consideration *available at* [http://www.healthlaw.org/index.php?option=com\\_content&view=article&id=281:medical-necessity-definition-model-medicaid-managed-care-contract-provisions&catid=42](http://www.healthlaw.org/index.php?option=com_content&view=article&id=281:medical-necessity-definition-model-medicaid-managed-care-contract-provisions&catid=42).

<sup>82</sup> BELLA & PALMER, *supra* note 69 at 12.

<sup>83</sup> THE LEWINGROUP, INCREASING USE OF THE CAPITATED MODEL FOR DUAL ELIGIBLES: COST SAVINGS ESTIMATES AND PUBLIC POLICY OPPORTUNITIES 7 (2008) *available at* <http://communityplans.net.dnnmax.com/NewsEvents/ACAPReleasesReportonSavingsfromManagedCare/tabid/284/Default.aspx>.

<sup>84</sup> KEVIN PRINDIVILLE & GEORGIA BURKE, NATIONAL SENIOR CITIZENS LAW CENTER ENSURING CONSUMER PROTECTION FOR DUAL ELIGIBLES IN INTEGRATED MODELS (2011) *available at* [www.nsclc.org/wp-content/uploads/2011/05/Final-Issue-Brief-2.pdf](http://www.nsclc.org/wp-content/uploads/2011/05/Final-Issue-Brief-2.pdf).

<sup>85</sup> H. CON. RES. 34 112<sup>th</sup> Cong. (2011); H.R. REP. NO. 112-58 (2011) House-passed Budget Resolution for FY 2012. House-passed Budget Resolution for FY 2012.

<sup>86</sup> SMDL #11-008 *supra* note 53; DRAFT MOU *supra* note 58 at 4.

passive enrollment, with beneficiary opt-out. Such an approach must however, include strong beneficiary protections.

- Providing a clear demonstration of adequate capacity at the state level;
- Establishing robust beneficiary education program, which describes available benefits and plans with a goal that most beneficiaries make an active plan choice;
- Reviewing Medicare and Medicaid claims data (for beneficiaries who do not make an active choice) to identify health care and support service providers used by individual beneficiaries and to the extent possible, enrolling beneficiaries in plans in which their providers participate (nothing would prohibit individuals from choosing other participating providers, once enrolled in a plan);
- Providing adequate notice (subject to CMS approval) to beneficiaries or their representatives that they will be enrolled in a capitated plan, and the implications of that enrollment in easily understandable terms;
- Providing clear instructions for beneficiary opt-out or enrollment in a different plan; and
- Providing transitional services covered outside networks to assure that services will not be disrupted for a reasonable period of time post-enrollment.

### ***Provider Network Adequacy***

Historically, federal policymakers have sought to assure network adequacy for vulnerable low-income populations under the Medicaid program. For example, federal legislation requires states to cover services provided by Federally Qualified Health Centers under Medicaid.<sup>87</sup> To assure network adequacy in medically underserved areas and to avoid the administrative burden of multiple standards applied to plans offered in the Medicare and Medicaid programs relative to private sector plans, the new state plan model could adopt an existing standard applicable to qualified health plans.<sup>88</sup>

Under this approach, plans would be required to contract with essential community providers, including federally qualified health centers, public hospitals and other providers. Under the proposed rule issued earlier this year related to the Health Insurance Exchanges, HHS clarifies that plans must contract with a “sufficient number” of essential community providers as defined under “section 340B(a)(4) of the PHS Act; and 340B “look-alikes” described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Under the proposed rule, issuers must include a “sufficient number” of essential community providers that serve predominantly low-income, medically underserved individuals, in the provider network.<sup>89</sup> Another approach to assuring network adequacy and avoiding disruption would be to permit enrollees to continue to receive care from existing providers during a transition period, or to require plans to contract with

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<sup>87</sup> 42 USC § 1396a(a)(10)(A); 42 USC § 1396d(a)(2)(C); 42 USC § 1396d(l)(2).

<sup>88</sup> ACA §1311(c)(1)(C).

<sup>89</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866, 41894, 41898 (proposed July 15, 2011) (to be codified at 45 C.F.R. parts 155 and 156).

providers so long as providers are willing to accept standard Medicaid contractual rates for services and meet quality standards. Plans should also demonstrate adequate capacity for long-term care support services.

### ***Marketing and Enrollee Communications***

Under the new state plan option, beneficiaries would be passively enrolled and permitted to opt-out. Passive enrollment should limit the need for plans to market to dual-eligible individuals, resulting in a reduction of marketing costs. Some have suggested that MA materials, developed by CMS, are not clear and could be more user-friendly.<sup>90</sup> Under the new state plan option marketing information made available to beneficiaries would be accessible and understandable to the beneficiaries that enroll in the plan, including individuals with disabilities and limited English proficiency. One important aspect of integrating programs for dual eligible individuals is the need for materials to permit comparison of information, including the full scope of benefits offered under the plan. Plans would be required to hire customer service representatives to answer questions.

As with marketing materials, communications to enrollees should be accessible and understandable. Under the new state plan option materials would be integrated and include outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal and external appeals and provider terminations. For both marketing materials and enrollee communications, the Medicare-Medicaid Coordination Office could be charged with developing a template for communications with enrollees, developed in consultation with states and plans.

### ***Grievances and Internal and External Appeals***

The state plan option would use a single set of complaints and internal appeals processes based on Medicare Advantage, Medicare Part D, and Medicaid managed care requirements. Generally, under Medicare, plans must establish a process for expedited review of grievances and appeals, must inform beneficiaries of their appeals rights, and must provide notice to enrollees on how to file grievances or to appeal plan decisions. CMS guidance outlines timelines under which plans must address grievances and appeals. A health plan that denies a service or payment for a service provided to a Medicare beneficiary must provide written notice to an enrollee.<sup>91</sup> Under certain circumstances related to the value of the claim, an enrollee may appeal a plan's decision to an Administrative Law Judge (ALJ). Beneficiaries or plans may appeal an ALJ decision to the Medicare Appeals Council (MAC). If the MAC declines to hear the appeal, parties may also seek judicial review of the decision.<sup>92</sup>

### ***Setting Payment Rates***

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<sup>90</sup> JUNE 2011 MEDPAC REPORT *supra* note 68 at 133.

<sup>91</sup> CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE MANAGED CARE MANUAL Ch. 13-10.3.2 (2007) available at <https://www.cms.gov/manuals/iom/itemdetail.asp?itemid=CMS019326>.

<sup>92</sup> *Id.* at Ch. 13-10.3.3.

Developing adequate payment and risk adjustment mechanisms for the new state plan option will be, perhaps, the most challenging component of developing a fully integrated model of care. Historically, MA and SNP plans have been reimbursed relative to a federal benchmark, which varies tremendously based on geographic area with little or no relation to the quality of care provided to Medicare beneficiaries. Further complicating this effort will be the need to achieve net savings at both the state and federal levels, while improving quality of care provided. Attempts to revise reimbursement have been fraught with problems, not the least of which are political battles between the "haves" and the "have-nots" based on regional MA plan reimbursement, but also the political tensions between those who support managed care in the Medicare and Medicaid programs, and those who believe that fee-for-service care is in the best interest of beneficiaries. Finally, the current state of the federal deficit as well as ongoing pressures on states to reduce Medicaid costs preclude any reimbursement model that would result in a net increase in Medicare and Medicaid spending. In fact, this plan must demonstrate savings and those savings must be scoreable by the Congressional Budget Office (CBO).

As such, critical to the success of the new state plan option will be actuarially sound rates that account for higher health care costs associated with delivering covered benefits and care to the dual eligible population. One of the primary issues that has limited the development and sustainability of the current SNP model, including the ability of new health plans to enter and stay in the market, is a lack of adequate reimbursement to cover the greater scope and usage levels of services necessary to properly deliver and manage care for the dual eligible population. This has been in part because rates for SNPs are based on MA benchmarks reflecting the level of care and services required by the Medicare population and covered by the program, not the dual eligible or Medicaid population. The lack of adequate reimbursement is particularly problematic in states with low MA benchmarks as health plans serving dual eligibles are unable to offset the higher costs of care with premiums or other forms of cost-sharing from a low-income dual eligible. State-based initiatives are particularly challenging where plans face significant rate variation across counties. As benchmarks have been reduced, this problem has become even worse forcing health plans out of the market and therefore reducing access and options for this already vulnerable population.

In addition, reimbursement rates for the new state plan option must take into account all of the services that dual eligibles typically need ranging from acute and ambulatory care to long term care services, behavioral health, and prescription drug services (e.g., the full spectrum of services available through the Medicare and Medicaid benefits). Rates also must account (e.g., be adjusted) for the higher levels of usage (and greater severity of need) of these services by dual eligibles, including institutionalized care and care in home- and community-based settings. Historically, MA rates used to set rates for SNPs have not been (or not adequately) adjusted for "frailty" to reflect the poorer health condition of the dual eligible population. Mental health needs, for example, are under recognized in the MA risk adjustment system because Medicare does not provide robust coverage of mental health services. Furthermore, the MA risk adjustment system does not adequately recognize the care needs of new dual eligibles as it assumes "average" risk in the first year of enrollment.



Taking these issues into consideration, the payment structure for the new state plan option would operate similarly to PACE with both the Medicare and Medicaid programs calculating and providing risk-adjusted prospective payments to a participating health plan. The health plan would then have the discretion to combine the payment streams as appropriate to manage and reimburse care for the eligible enrolled individuals. The new state plan option would also include an opportunity for shared savings. These payment elements are described more fully below.

### **Medicare**

As noted above, relying on the MA benchmark to determine the Medicare portion of the capitated payment for the current SNP model has resulted in reimbursement rates that have not adequately or accurately reflected the scope and usage of care of the dual eligible population. Medicare claims data clearly indicates that dually eligible Medicare beneficiaries are more expensive to the Medicare program than those that are not also eligible for Medicaid. As part of the rate-setting process for the new state plan option, it will be important for CMS to conduct an actuarial analysis specific to Medicare beneficiaries in the dual eligible population, including utilization and costs of care for this population. This analysis would enable CMS to develop a separate rate based on the actual usage and care needs of dually eligible individuals. Furthermore, the new payment rate would reimburse providers appropriately for services provided to dual eligibles regardless of where the dual resides (within and across states) to avoid the gaps in MA plan availability associated with county-specific benchmark rate-setting specific to the Medicare population.

### **Medicaid**

To determine the Medicaid rate, states could conduct an actuarial analysis that would include 1) projected enrollment (including duals over and under 65); 2) medical service utilization estimates for both Medicare (as indicated by Medicare dual eligible target rate analysis and historical MA/SNP bids) and Medicaid (as indicated by either Medicaid FFS or managed care data); 3) Medicaid cost-sharing for Medicare services; and 4) projected administrative expenses including marketing, sales, administration, salaries; and expenses (direct and contracted). In addition, states could review 1) the Medicare analysis for the Medicare dual eligible rate (described above); 2) historical MA and/or SNP bid data (if available from the plans, since CMS may not share this information) —keeping in mind that this historical bid data is based on Medicare payment rates and may not include the full range of services or service usage necessary for dual eligibles—; 3) PACE rates (if available); 4) and historical Upper Payment Limit (UPL) information and combine this information with the state’s Medicaid data. While historically, states have relied on FFS claims data to calculate appropriate rates for the PACE population and Medicaid managed care, as more and more states are moving towards a predominantly managed care approach to their Medicaid populations, states and plans should consider using a regression-based approach to setting the Medicaid rate using the factors identified above.

### **Impact of Integrated Benefits on Rate-Setting**

By integrating the Medicare and Medicaid benefits as described above, it is anticipated that the total cost of benefits for dual eligibles will be reduced. For example, a dual eligible living in a home-based setting whose care is being managed and coordinated, may require fewer hospitalizations resulting in savings to the Medicare program and avoid institutionally-based long-term care services resulting in savings to the Medicaid programs and the health plans administering the combined benefit. To address this issue, state Medicaid programs working closely with CMS could evaluate the impact and interaction of an integrated benefit model on the costs of care for dual eligibles and adjust the Medicare and Medicaid reimbursement targets appropriately. States and CMS could conduct this evaluation on an annual basis beginning after year one (1) of the new state plan option model.

### **Risk Adjustment**

Most important to the rate-setting process for the state plan option, will be the risk adjustment process that is used. Similar to the current CMS hierarchical conditions categories (HCC) adjusters used for Medicare Advantage and SNPs, CMS could adjust the state plan option rates (assuming differences across counties and states) for standard demographic and enrollment factors (e.g., age, sex, aged versus disability eligibility status, Medicaid eligibility, and institutional status) and health status. Similar to Part D payments, CMS could also adjust the state plan option rates for Medicaid status, low-income, and institutional status. Historically, CMS has used a frailty adjuster for the PACE program, the WI and MN demonstrations, and potentially starting in 2012 for Dual SNPs that are fully integrated including contracts for Medicaid long term care and other services.<sup>93</sup> However, these adjusters, including the current “frailty” adjuster do not fully account for the poor health condition or “frailer” status of many dual eligibles. For example, dementia, a diagnosis that is much more prevalent in the dual eligible population, is not included in the list of diagnoses used in the HCC-model. Preliminary MedPAC research also indicates that the frailty adjuster used in the PACE program under predicts the costs associated with care for the PACE population.<sup>94</sup> Finally, frailty adjusters are typically plan specific, not person specific; therefore if a plan covers a broader population than frail dual eligible beneficiaries, it cannot qualify for the adjuster. Rather than continuing to use adjustment models that were developed for other programs (e.g., MA or PACE), the state plan option would have a risk adjustment model that more accurately reflects the scope and usage levels of care needed for the dual eligible population. This model would include a broader set of diagnoses that reflect the care needs of dual eligibles, including comorbidities, complications associated with frailty, and behavioral health. This model also would take into account actual service utilization ideally over the course of the previous 12 months at the individual level, as well as functional status (using activities of daily living scale), and mortality of the dually eligible population. This is particularly important for Medicaid-eligible individuals who age into

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<sup>93</sup> The ACA allows CMS to pay frailty adjusters to SNPs for dual eligible members if the SNPs have a fully-capitated contract with the state beginning in 2011. However, CMS has determined that it has insufficient information to determine frailty level to make the adjustment in 2011. CMS anticipates having sufficient data to calculate frailty adjustments for 2012.

<sup>94</sup> CHRISTINE AGUIAR & KELLY MILLER, MEDICARE PAYMENT ADVISORY COMMISSION, COORDINATING CARE FOR DUAL-ELIGIBLE BENEFICIARIES THROUGH THE PACE PROGRAM (2011) *available at* [http://www.medpac.gov/transcripts/September%20duals%20presentation\\_final.pdf](http://www.medpac.gov/transcripts/September%20duals%20presentation_final.pdf).

Medicare and become dual eligibles as the current MA adjustments do not address care delivered in the first year of Medicare eligibility (which are typically higher cost).

### **Risk Corridors**

CMS, states, and plans could also consider developing risk corridors in the state plan option similar to those used for Part D plans and PACE plans to enable plans to transition from partial to full risk models. This is particularly important for plans during the first year for new duals, which is often very costly to both programs and difficult to account for by a standard adjustment. Similarly, the costs of permanent nursing home placement are often very high and for individuals who become duals after placement in a nursing home, this can be a significant barrier for plans to stay in the market. Furthermore, state and plan-based start-up and management costs are often higher in the first year or two as programs become established. Risk corridors would allow Medicare to retain more risk through the provision of higher payment rates during the first two to three years of the program to enable plans to become operational and viable such that they can sustain the risk. Over the course of five years, the risk would transition from CMS to the plans. The recent risk adjustment transition for the PACE program, under which risk adjustment transitioned from a straight frailty adjuster to a combination of an increasing proportion of risk adjustment plus the frailty adjuster, provides a good example that CMS could apply to the state plan option program.

### **Shared Savings**

One of the primary concerns with current attempts to integrate care for dual eligibles is that the savings accrue to the Medicare program (e.g., directly to Medicare through reduced rates of inpatient hospitalization and directly to the federal government as reduced match payments for lower Medicaid costs). A core benefit of the state plan option would be to enable CMS and the states to share equally in savings achieved through financial and clinical integration of care for dual eligibles after accounting for the initial higher administrative costs to the state of setting up the program. To balance initial higher payments from CMS (through the risk corridor approach described above) with the initial start-up costs for states, the new state plan option could deploy a phased-in approach to shared savings. For example, in the first year, CMS could receive 65% of any savings and then five percent less of the savings annually until CMS and the state both receive 50% of savings. This calculation could be modified depending on actual start-up costs to the state and additional costs if a state experiences a high rate of participation and care needs among its eligible dual population particularly for home and community-based services. Finally, a portion of any savings accrued to the state and the federal government also could be used to provide additional benefits or support services to enrollees – a feature of the current MA program that should not be lost in future shared savings models.

### **Annual Renegotiation**

Similar to MA, SNPs, and PACE, the payment rates would be renegotiated on an annual basis taking into consideration the lessons learned as the state plan option program is implemented and

incorporating utilization and other relevant data from prior years experience. Annual updates also will be critical to account for the increasing frailty of the dual population over time.

### **Access to Information for Rate-Setting and Care Coordination**

Critical to this entire process, will be the sharing of information between CMS, the states, and plans for both rate-setting and to determine savings achieved through greater care coordination. Currently, state Medicaid programs have little or no information on Medicare-provided services regardless of whether they receive reimbursement under FFS or MA. The new state plan option model should alleviate some of the challenges associated with lack of access to information about services delivered as a single entity will be coordinating the care for the dual eligible beneficiary. While CMS is limited in the information it can share on the MA side due to the proprietary information included in bid documents, the plans themselves may share this information with both CMS and the state. Furthermore, the current MA bid pricing tool is a good source of information on what Medicare is paying for Medicare-covered services as well as which services and how they might interact with the simultaneous availability of Medicaid-covered services. States should work closely with CMS and health plans to share historical data on dual eligibles to the fullest extent allowable.

### ***Quality***

Another critical element of the state plan option will be its ability to demonstrate that it is delivering high quality care to dual eligibles and ideally reducing the cost growth of such care as well. While there are a number of quality measurement programs and related measures that apply to both health plans and providers (e.g., HEDIS, CAHPS, HOS), these measures do not capture the health care needs and usage patterns of the dual eligible population. Similar to the reimbursement rates developed for the MA program, the available quality measures were designed in large part based on the care needs and patterns of the Medicare population or under-65 able population. As such, under the new state plan option states would work closely with health plans and CMS to develop a new set of quality and access measures that are specific to the more vulnerable dual eligible population and focus on outcomes measures, including rates of emergency room use, long term care, hospital admission and readmission rates, and medication errors. These measures could be incorporated in to the Medicare STARS quality bonus demonstration and future incentive programs as well. In some cases, it may be possible to modify existing measure sets to reflect the care needs and usage patterns of the dual eligible population. These modified measures could provide a base of measures that would be readily available to put into use. As with existing quality measurement programs, it will be important that [CMS/states] provide the measurement results to health plans, consumers, and providers in accessible and understandable formats to enable quality improvement and consumer engagement.

Furthermore, some states now require Medicaid plans to demonstrate that they have processes in place to assess each new enrollee's health needs, housing needs, and other social supports and develop an individualized plan to ensure the needs of the enrollee are met taking into consideration the full range of issues that may be impacting the individual's health and future

health needs. These issues are particularly acute for the dual eligible population as well. As such, these requirements should extend to plans participating in the state plan option with primary oversight responsibility at the state level. Under the new state plan option, CMS and the states would jointly conduct quality review and reporting through a single comprehensive process coordinated at the state level.

### ***Beneficiary Protections***

If states are permitted to use a system of passive enrollment for dual-eligible individuals with an opt-out, the new state plan option must include strong consumer protections to assure that individuals or their families have a meaningful process for opting-out of the program, including opting-in to other plans or back into FFS Medicare. In addition to requirements relating to network adequacy, quality of care and other requirements, Congress should include provisions requiring plans to meet additional standards, including many of those recommended by the National Senior Citizens' Law Center (NSCLC):<sup>95</sup>

- Plans should be required to have consumer advisory boards comprised of plan enrollees and their representatives. Plans should also have meaningful enrollee representation on governing boards;
- Plans should be required to work with enrollees and their families to develop individualized care plans that maximize consumer choice in decisions relating to patient care, individual care plans, coverage denials and appeals rights;
- States should oversee communications between plans and beneficiaries and should require plans to use templates developed in conjunction with the Medicare-Medicaid Coordination Office. All information should be accessible and understandable to the beneficiaries that will be enrolled in the plan, including individuals with disabilities and limited English proficiency;
- Plans should be required to provide notice and explanations regarding enrollment and disenrollment options, as well as appeals rights;
- Services should be culturally and linguistically appropriate and physically accessible;
- Existing federal privacy laws should apply to programs; and
- Enrollment should be phased-in based on capacity at state level.

## **V. CONCLUSION**

Despite the significant progress authorized by the ACA and recent initiatives of the Medicare-Medicaid Coordination Office and Innovation Center, significant issues remain as these new integrated models of care are developed and implemented. Development and testing of these models under the current regulatory structure will take a minimum of four years based on a targeted implementation date of late 2012. Given the goal of improving quality and efficiency of care for dual eligible individuals, pressure on states to reduce Medicaid costs, and pressure at the federal level to take action to slow the rate of growth in both Medicare and Medicaid

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<sup>95</sup> See PRINDIVILLE & BURKE *supra* note 83.

expenditures, Congress should explore authorization of a new state option under Medicaid, with its own distinct identity similar to that accorded PACE.

Under this new state option, states, the federal government and plans would work together to establish and oversee a model to provide integrated care for dual eligible individuals. States would administer the program and elect to adopt a new model of care through a Medicaid state plan amendment. The CMS Medicare-Medicaid Coordination Office would work with states to assure adequate beneficiary protections and quality, while giving states the ability to begin to better integrate care in the short-term while CMS tests additional models of care through the Innovation Center. Should Congress adopt this approach, CMS, states and plans should collaborate to assure improved quality of care for dual eligible individuals, strong beneficiary protections and meaningful input for consumers.

## Appendix A: Pre-ACA Models of Care for Duals

Over time, Congress has authorized some flexibility for Medicare and Medicaid to deliver services through mechanisms that foster greater care coordination (e.g., through managed care plans as opposed to FFS such as the Medicare Advantage program and SNPs). However, with few exceptions, the flexibility has been program specific and failed to include requirements for cross-program coordination for dual eligibles. In fact, federal requirements still prohibit states from requiring dual eligibles to enroll in a managed care plan, either MA or Medicaid managed care.<sup>96</sup>

The BBA created the Medicare+Choice program (M+C) in order to encourage wider availability of managed care options through health maintenance organizations (HMOs) and the participation of other types of coordinated care plans.<sup>97</sup> The BBA also broadened state Medicaid authority to require most Medicaid beneficiaries to enroll in managed care organizations (MCOs), not including dual eligibles, without obtaining a waiver and relaxed MCO enrollment requirements so that MCOs could contract exclusively with state Medicaid programs.<sup>98</sup>

With passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Congress took additional steps to increase the availability and utilization of managed care in the Medicare and Medicaid programs allowing looser arrangements and out of network access to providers. In addition to changing the name of the program from the Medicare+Choice program to the MA program,<sup>99,100</sup> the MMA authorized payment rate increases for providers and plans to increase participation rates.<sup>101,102</sup> The MMA also authorized Medicare to contract with preferred provider organizations (PPOs) to allow more flexibility for providers and beneficiaries wishing to access providers outside of their managed care network.<sup>103</sup>

Section 646 of the MMA also authorized Medicare Health Care Quality Demonstration Programs establishing 5-year demonstration programs designed to expand the physician group practice demonstration model and evaluate models designed to foster greater care coordination and

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<sup>96</sup> 42 C.F.R. § 438.50 (2008).

<sup>97</sup> Balanced Budget Act of 1997 § 4001, 42 USC 1395w-21 (2006).

<sup>98</sup> § 4702; § 4709; § 4731. Prior to passage of the BBA, MCOs could not do business exclusively with Medicaid. They were subject to the statutory “75/25” rule which provided that Medicaid and Medicare beneficiaries could account for no more than 75 percent of an MCO’s enrollment and section 1915(b) did not give the Secretary the authority to waive this requirement. By eliminating this requirement, the BBA improved market conditions for managed care organizations wishing to contract with Medicaid enabling them to contract directly and exclusively with MCOs.

<sup>99</sup> *See, e.g.*, Medicare Prescription Drug, Improvement and Modernization Act of 2003, PUB. L. NO. 108-173 §§ 201, 211. 117 Stat. 2176 (2003); *see also* OFFICE OF LEGISLATION, CMS LEGISLATIVE SUMMARY, SUMMARY OF H.R. 1 MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173 (2004) *available at* <http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf>.

<sup>100</sup> Medicare Prescription Drug, Improvement and Modernization Act of 2003 § 201, 42 U.S.C. 1395w-21 – 28.

<sup>101</sup> *Id.* at § 211.

<sup>102</sup> *Id.* at § 221.

<sup>103</sup> In a PPO, a beneficiary gets most of their health care from a network of providers, but can also choose to go outside of the network and pay more for their desired or “preferred” provider.



disease management.<sup>104</sup> This section expanded the definition of health care groups to include regional coalitions and integrated delivery systems in addition to physician groups. Most importantly, Section 646 allowed “health care groups” to incorporate approved alternative payment systems and modifications to the traditional FFS and MA benefit package. Authorized demonstrations must be budget neutral and can cover either FFS or MA beneficiaries. While the authorization of these demonstrations indicated a commitment to testing new and innovative payment methods to improve quality of care and reduce costs through demonstration programs,<sup>105</sup> unfortunately it did little to encourage states to integrate Medicaid coverage into the demonstrations.

The MMA also created special needs plans, or SNPs, designed to address the needs of three special populations: dual eligibles, beneficiaries in nursing facilities or similar institutions, and beneficiaries with severe or disabling chronic conditions. Specifically, the MMA authorized Medicare to pay a SNP a capitated amount to manage the care covered and reimbursable under Medicare only (not Medicaid) for enrolled dual eligibles.<sup>106</sup> Congress wrote SNPs into statute as MA plans, must structure services, payments and contracts accordingly. Although SNPs have been promoted as a viable mechanism to integrate Medicare and Medicaid services, SNPs, even dual eligible SNPs (those that simultaneously have a managed care contract with the state Medicaid agency), are not required to contract with states to provide Medicaid benefits and many appear not to.<sup>107</sup> Beginning in 2010, SNPs interested in new or expanded service areas will be required to contract directly with state Medicaid agencies (as required by the Medicare Improvements for Patients and Providers Act of 2008 [MIPPA]) for this purpose.<sup>108</sup> However, this requirement does not apply to existing SNPs that are not interested in expansion to new service areas.

As with FFS, Medicaid is the secondary payer for dual eligibles enrolled in managed care, and payment for beneficiaries’ Medicare cost-sharing is inconsistent due in part to administrative complications and in part to varying state law and policies. States may either allow or forbid enrollment in Medicaid managed care if the beneficiary is in an MA plan. Additional complications arise if services are provided to a beneficiary by providers that are not in the Medicaid HMO’s network or if services are provided under Medicare that require pre-authorization by the Medicaid HMO that refuses to pay the Medicare cost-sharing. Finally, states are not required to pay MA plan premiums on behalf of dual eligibles. As zero premium options have declined under MA in recent years, this has become a more significant issue. Some states have agreed to pay MA premiums for plans that offer additional services that Medicaid would otherwise cover, but the underlying statutory complication remains.

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<sup>104</sup> Medicare Prescription Drug, Improvement and Modernization Act of 2003, PUB. L. NO. 108-173 § 646, 117 Stat. 2324 (2003).

<sup>105</sup> *Id.* at §§ 235, 306, 409, 410A, 417, 418, 434, 605, 641, 648, 649, 651, 702, 703, 723, 922, 924.

<sup>106</sup> *Id.* at § 231.

<sup>107</sup> MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO CONGRESS: THE MEDICARE ADVANTAGE PROGRAM: AVAILABILITY, BENEFITS, AND SPECIAL NEEDS PLANS, Ch. 9 (2006) *available at* [http://www.medpac.gov/publications/congressional\\_reports/Jun06\\_Ch09.pdf](http://www.medpac.gov/publications/congressional_reports/Jun06_Ch09.pdf).

<sup>108</sup> Medicare Improvements for Patients and Providers Act of 2008, PUB. L. NO. 110-275 § 164, 122 Stat. 2571 (2008).

Other than authorizing MA and SNPs, which only manage the Medicare benefit, the MMA failed to take any further steps towards improving care coordination for dual eligibles through better integration of Medicare and Medicaid benefits. MMA did not require SNPs to participate in Medicaid managed care, cover Medicaid benefits, or guarantee Medicaid payment. While some states entered into separate contracts with SNPs to integrate Medicare and Medicaid funding and services at the plan level, many states did not perpetuating the lack of coordination for dual eligibles.

On the Medicaid side, Section 1932(a) of the Social Security Act provides state Medicaid agencies with authority to provide the Medicaid benefit through mandatory or voluntary managed care programs on a statewide basis or in limited geographic areas.<sup>109</sup> However, the Social Security Act expressly prohibits states from mandating enrollment as a condition of coverage in the case of dual eligibles.<sup>110</sup> Although there is no mandatory enrollment of dual eligibles, duals may voluntarily enroll and thus can be included in the managed care program. Section 1932(a) is not a waiver authority, but rather provides state plan authority to file an amendment to the state Medicaid plan. In contrast to the waiver authorities, Section 1932 does not require states to demonstrate that their Medicaid managed care initiative is cost effective or budget neutral.

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<sup>109</sup> 42 U.S.C. § 1396u-2 (2006).

<sup>110</sup> Social Security Act § 1932(a)(2)(B), 42 U.S.C. § 1396u-2(a)(2)(B) (2006). Dual eligibles are not exempt from mandatory enrollment in MCOs under the section 1915 or section 1115 waiver authorities. *See* 42 U.S.C. §§ 1315, 1396n.

## APPENDIX B: PACE

Medicare Payment. Under a PACE program agreement, CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in a payment area based on a rate it pays to a Medicare Advantage (MA) organization.<sup>111</sup> The PACE program agreement specifies the methodology used to calculate the monthly capitation amount applicable to a PACE organization.<sup>112</sup> The monthly capitation amount is based on the Part A and Part B payment rates established for purposes of payment to MA organizations with a CMS adjustment for risk that reflects an individual’s health status.<sup>113</sup> CMS ensures that payments take into account the comparative frailty of PACE enrollees relative to the general Medicare population and may adjust the monthly capitation amount to take into account other factors CMS determines to be appropriate.<sup>114</sup> The monthly capitation payment is a fixed amount, though, regardless of changes in a participant’s health status. Moreover, “CMS does not pay for services to the extent that Medicare is not the primary payer” for such services.<sup>115</sup>

Medicaid Payment. Also under the PACE program agreement, the state administering agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.<sup>116</sup> The PACE organization and the state administering agency negotiate the monthly capitation payment amount, representing an amount that: 1) “is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program;” 2) “takes into account the comparative frailty of PACE participants;” 3) “is a fixed amount regardless of changes in the participant’s health status;” and 4) “can be renegotiated on an annual basis.”<sup>117</sup>

Required and Waived Services. If a Medicare beneficiary or Medicaid recipient chooses to enroll in a PACE program, Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.<sup>118</sup> The participant must receive Medicare and Medicaid benefits solely through the PACE organization.<sup>119</sup> “The PACE benefit package for all participants, regardless of the source of payment, must include:” 1) “All Medicare-covered items and services;” 2) “All Medicaid-

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<sup>111</sup> 42 U.S.C. § 1395eee(d); 42 C.F.R. § 460.180(a).

<sup>112</sup> 42 C.F.R. § 460.180(b)(1).

<sup>113</sup> *Id.* at § 460.180(b)(2)-(3). If the actual number of Medicare participants differs from the estimated number of participants on which the amount of the prospective monthly payment was based, CMS adjusts subsequent monthly payments to account for the difference. *Id.* at § 460.180(b)(8).

<sup>114</sup> *Id.* at § 460.180(b)(5). For beneficiaries who require ESRD services, the monthly capitation amount is based on the MA ESRD risk adjustment model. *Id.* at § 460.180(b)(8).

<sup>115</sup> *Id.* at § 460.180(d)(1). The PACE organization has a responsibility under the program agreement to identify payers that are primary to Medicare, determine the amounts payable by those payers, and coordinate benefits to Medicare participants with the benefits of the primary payers. *Id.* at § 460.180(d)(2).

<sup>116</sup> 42 U.S.C. § 1396u-4(d); 42 C.F.R. § 460.182.

<sup>117</sup> *Id.* at § 460.182(b). “State procedures for the enrollment and disenrollment of participants in the state’s system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month, are included in the PACE program agreement” *Id.* at § 460.182(d)

<sup>118</sup> 42 C.F.R. § 460.90(a); *see also* 42 U.S.C. § 1396u-4(g); 42 U.S.C. § 1395eee(g).

<sup>119</sup> 42 C.F.R. § 460.90(b).

covered items and services, as specified in the state’s approved Medicaid State plan;” and 3) “Other services determined necessary by the interdisciplinary team to improve and maintain the participant’s overall health status.”<sup>120</sup>

The scope of hospital insurance benefits and supplemental insurance benefits are required services under PACE for Medicare participants except for the following Medicare requirements which are waived for purposes of PACE: (1) provisions that limit coverage of institutional services; (2) provisions relating to payment for benefits; (3) provisions that limit coverage of extended care services or home health services; (4) provisions that impose a 3-day prior hospitalization requirement for coverage of extended care services; and (5) provisions that may prevent payment for PACE program services that are provided to PACE participants.<sup>121</sup>

Service Delivery. The PACE organization is required to establish and implement a written plan to furnish care that meets the needs of each participant in all care settings, 24 hours a day, every day of the year, including comprehensive medical, health, and social services that integrate acute and long-term care.<sup>122</sup> PACE centers serve as the focal point for coordination and provision of most PACE services and “include a primary care clinic, areas for therapeutic recreation, restorative therapies, socialization, personal care, nutritional counseling, and dining.”<sup>123</sup> These services can also be furnished in the home and inpatient facilities.<sup>124</sup>

Each PACE center has an interdisciplinary team that assesses and meets the needs of each participant and determines the frequency of a participant’s attendance at the center, based on the needs and preferences of the participant.<sup>125</sup> Each interdisciplinary team is composed of at least the following members: (1) primary care physician; (2) registered nurse; (3) master’s-level social worker; (4) physical therapist; (5) occupational therapist; (6) recreational therapist or activity coordinator; (7) dietician; (8) PACE center manager; (9) home care coordinator; (10) personal care attendant; and (11) driver.<sup>126</sup> The interdisciplinary team develops a comprehensive plan of care for each participant specifying the care needed and identifying the measurable outcomes to be achieved.<sup>127</sup> The team then implements, coordinates, monitors, and evaluates the plan of care, including defined outcomes, and makes changes as necessary.<sup>128</sup>

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<sup>120</sup> *Id.* at § 460.92; *see also* 42 U.S.C. § 1396u-4(b)(1)(A)(i)-(ii); 42 U.S.C. § 1395eee(b)(1)(A)(i)-(ii).

<sup>121</sup> 42 C.F.R. § 460.94(b); *see also* 42 U.S.C. § 1396u-4(g); 42 U.S.C. § 1395eee(g); 42 C.F.R. § 460.96 (setting forth the following excluded services under PACE: (1) “Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service;” (2) “In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care);” (3) “Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy;” (4) “Experimental medical, surgical, or other health procedures;” and (5) “Services furnished outside of the United States,” with minor exceptions).

<sup>122</sup> 42 C.F.R. § 460.98; *see also* 42 U.S.C. § 1396u-4(b)(1)(B); 42 U.S.C. § 1395eee(b)(1)(B).

<sup>123</sup> 42 C.F.R. § 460.6; *see also Id.* at § 460.98(c).

<sup>124</sup> *Id.* at § 460.98(b)(2).

<sup>125</sup> *Id.* at §§ 460.98(e), 460.102(a).

<sup>126</sup> *Id.* at § 460.102(b)(1)-(11).

<sup>127</sup> *Id.* at § 460.106(a)-(b).

<sup>128</sup> *Id.* at § 460.106(c)-(d).

Federal/State Monitoring and CMS Sanction Authority. “During a trial period, CMS, in cooperation with the state administering agency, conducts comprehensive annual reviews of the operations of a PACE organization to ensure compliance with the PACE requirements.”<sup>129</sup> Ongoing monitoring continues after conclusion of the trial period by CMS, in cooperation with the state administering agency.<sup>130</sup> CMS always maintains authority to impose sanctions, conduct enforcement actions, and terminate the PACE program agreement for certain violations of the PACE program agreement.<sup>131</sup> CMS may suspend enrollment and may either suspend Medicare payment to the PACE organization or deny payment to the state for medical assistance for services furnished under the PACE program agreement if a PACE organization commits one or more violations.<sup>132</sup> CMS may also impose civil money penalties up to a set amount for each violation.<sup>133</sup>

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<sup>129</sup> *Id* at § 460.190; *see also* 42 U.S.C. § 1396u-4(e); 42 U.S.C. § 1395eee(e).

<sup>130</sup> 42 C.F.R. § 460.192; *see also* 42 U.S.C. § 1396u-4(e); 42 U.S.C. § 1395eee(e).

<sup>131</sup> 42 C.F.R. §§ 460.40-.54.; *see also* 42 U.S.C. § 1396u-4(e); 42 U.S.C. § 1395eee(e).

<sup>132</sup> 42 C.F.R. § 460.42; *see also* 42 U.S.C. § 1396u-4(e); 42 U.S.C. § 1395eee(e).

<sup>133</sup> 42 C.F.R. § 460.46.

## APPENDIX C: Medicare and Medicaid Demonstration and Waiver Authorities

Section 1115 Demonstration and Waiver Authority. Section 1115 of the Social Security Act authorizes the Secretary to waive certain federal requirements for the purpose of conducting pilot, experimental, or demonstration projects that are likely to promote the objectives of the Medicaid program.<sup>134</sup> States have used this federal waiver authority to change their program in ways that would not otherwise be allowable under federal requirements (e.g., expanding coverage to new groups of people, modifying the delivery system, or changing the benefit package design).

There are two types of Medicaid authority that may be requested under Section 1115. To operate demonstration programs, Section 1115(a)(1) allows the Secretary to waive provisions of Sections 1902, 402, and 1002 (State Plan requirements) and 1402, 2, and 1602 (State Plans for Aid to the Permanently and Totally Disabled and State Old-Age Plans and their eligibility requirements). Section 1115(a)(2) allows the Secretary to provide federal financial participation for costs that otherwise cannot be matched under Sections 1903, 3, 455, 1003, 1403, 1603, and 1903 (requirements for payments to states). Furthermore, the costs of the waiver project, which would not otherwise be a permissible use of funds under the Social Security Act provisions for block grants to states for temporary assistance for needy families and which are not included as part of the allowable costs for cooperative research or demonstration projects, are regarded as a permissible use of funds for the duration of the waiver project.

Projects are generally approved to operate for a five-year period and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be “budget neutral” over the life of the project, meaning they cannot be expected to cost the federal government more than it would cost without the waiver. Importantly, Section 1115 waives the beneficiary freedom of choice provision allowing states to require eligible beneficiaries to participate in the waiver program.

Section 1915 Waivers. Section 1915 of the Social Security Act<sup>135</sup> sets forth a series of provisions respecting inapplicability and waiver of certain Medicaid requirements. Section 1915(a) provides an exception to state plan requirements for voluntary managed care. Specifically, the Secretary is authorized to waive requirements under Section 1902(a) of the Act, including waiver from the requirement that the state plan be in effect in all political subdivisions of the state, waiver from the required list of covered services in the section, and waiver from the requirement that the state may not restrict the choice of the Medicaid individuals from obtaining medical assistance from any institution, agency, community pharmacy, or person qualified to perform the services by enrolling Medicaid eligible individuals in primary care case management or Medicaid managed care.<sup>136</sup> The Secretary can use this to authorize voluntary managed care programs on a statewide basis or in limited geographic areas. While, it does not require a formal

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<sup>134</sup> 42 U.S.C. § 1315 (2006).

<sup>135</sup> 42 U.S.C. § 1396n (2006).

<sup>136</sup> *Id.*

waiver or change to the state plan, it is not so broad as to allow mandatory enrollment for states wishing to integrate care in that manner.

Section 1915(b) of the Social Security Act provides authority for the Secretary to waive other requirements under Section 1902 honoring the choice of providers for Medicaid beneficiaries by allowing: (1) implementation of a primary care case management system or a specialty physician services arrangement which restricts the provider from whom an individual can obtain medical care services; (2) a locality to act as a central broker in assisting individuals in selecting among competing health care plans; (3) sharing with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care; and (4) restricting the provider from whom an individual can obtain services to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the state plan, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis.<sup>137</sup> Prohibitions on waiving the provision of Medicaid payment and services from rural health clinics services and federally-qualified health center services, or waiving restrictions that would substantially impair access to services of adequate quality when medically necessary are maintained.

In general, this waiver allows for two-year renewable waivers for mandatory enrollment in managed care.<sup>138</sup> Alternatively or in addition to managed care, a state may use selective contracting with providers on a statewide basis or in limited geographic areas. Section 1915(b) waivers must demonstrate their cost-effectiveness and must not substantially impair beneficiary access to medically necessary services of adequate quality. As opposed to the authority provided under Section 1932(a), this waiver option allows mandatory enrollment for dual eligibles in managed care.<sup>139</sup>

Finally, Section 1915(c) of the Social Security Act provides authority for Home and Community Based Services Waivers.<sup>140</sup> This waiver authority allows states to provide long-term care services delivered in community settings as an alternative to institutional settings. This applies to individuals for whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the state plan.<sup>141</sup> Section 1915(c) waivers must be cost neutral and are renewable for five years after the initial three-year approval. States may opt to simultaneously utilize section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly

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<sup>137</sup> *Id.* at § 1396n(b)(1)-(4).

<sup>138</sup> *Id.* at § 1396n(h).

<sup>139</sup> In contrast to Sections 1915(a), 1932(a), and 1937 which expressly prohibit mandatory enrollment of dual eligibles, Section 1915(b) does not.

<sup>140</sup> 42 U.S.C. § 1396n(c).

<sup>141</sup> *Id.* at § 1396n(c)(2)(B).

populations.<sup>142</sup> In essence, states use the 1915(b) authority to limit freedom of choice and 1915(c) authority to target eligibility for the program and provide home and community-based services. By doing this, states can provide long-term care services in a managed care environment or use a limited pool of providers.

States can implement 1915(b) and 1915(c) concurrent waivers as long as they meet all federal requirements for both programs. Therefore, when submitting application for concurrent 1915(b)/(c) programs, states must submit a separate application for each waiver type and satisfy all of the applicable requirements. For example, states must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver. States also must comply with the separate reporting requirements for each waiver. Because the waivers are approved for different time periods, renewal requests must be prepared separately and submitted at different points in time.

Section 402/222 Demonstration and Waiver Authority. This waiver authority allows the Secretary to waive Medicare and Medicaid requirements to demonstrate new approaches to provider reimbursement, including tests of alternative payment methodologies, demonstrations of new delivery systems, and coverage of additional services to improve overall efficiency of Medicare.<sup>143</sup> The Secretary is authorized, either directly or through grants or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects, to determine whether, and if so, which type of fixed price or performance incentive contract would have the effect of inducing to the greatest degree effective, efficient, and economical performance of agencies and organizations making payment under agreements or contracts with the Secretary for health care and services under the Medicare and Medicaid programs.<sup>144</sup>

Other purposes allowed under this waiver provision include: (1) “to determine whether, and if so, which changes in methods of payment or reimbursement” for health care and services for Medicare and Medicaid, “including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;”<sup>145</sup> and (2) “to determine whether the rates of payment or reimbursement for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State would

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<sup>142</sup> Centers for Medicare & Medicaid Services, *Medicaid State Waiver Program Demonstration Projects - General Information, Combined 1915(b)(c) Waivers*,

[http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/06\\_Combined1915bc.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/06_Combined1915bc.asp) (last visited Oct. 27, 2011).

<sup>143</sup> 42 U.S.C. § 1395b-1 (2006). The Social Security Act Amendments of 1967 set forth a waiver demonstration provision in section 402(a), which was amended by section 222(a) and (b) of the Social Security Act Amendments of 1972, codified at 42 U.S.C. § 1395b-1 (2006). See Social Security Act Amendments of 1967, PUB. L. NO. 90-248 § 402(a), 81 Stat. 821 (1967); Social Security Act Amendments of 1972 § 222(b), 42 U.S.C. § 1395b-1 (2006).

<sup>144</sup> 42 U.S.C. § 1395b-1(a)(1)(F) (2006).

<sup>145</sup> 42 U.S.C. § 1395b-1(a)(1)(A) (2006).



have the effect of reducing the costs of such programs without adversely affecting the quality of such services”.<sup>146</sup>

The Secretary may waive compliance with Medicare and Medicaid requirements under Titles XVIII and XIX of the Social Security Act if requirements relate to reimbursement or payment on the basis of reasonable cost or charge, or to reimbursement or payment only for services or items specified in the demonstration.<sup>147</sup> Costs incurred in the demonstration project in excess of the costs that would otherwise be reimbursed or paid under the programs may be reimbursed or paid to the extent that the waiver applies to them, with excess being borne by the Secretary.<sup>148</sup> Additionally, no demonstration project may be engaged in or developed until the Secretary obtains the advice and recommendations of specialists who evaluate the proposed demonstration project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed demonstration project, and its relationship to other similar projects already completed or in process.<sup>149</sup>

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<sup>146</sup> 42 U.S.C. § 1395b-1(a)(1)(C) (2006). Other relevant allowable purposes not discussed include: (B) payment for additional services not already allowed by Medicare or Medicaid programs through state plans, (D) combined rates for teaching activities and resident treatment in medical education programs, (E) to determine whether intermediate care facilities and homemaker services are suitable alternatives to post hospital benefits currently provided, (G) to determine payment and appropriate services for administration by nurse practitioners, (H) to experiment with day care services involving personal care and supervision, (I) to determine whether extended services provided by clinical psychologists are appropriate, (J) to develop improved methods for investigation and prosecution of Medicare and Medicaid fraud, and (K) to determine whether competitive bidding or other methods of reimbursement would be appropriate. *Id.* at § 1395b-1(a).

<sup>147</sup> 42 U.S.C. § 1395b-1(b) (2006).

<sup>148</sup> *Id.*

<sup>149</sup> *Id.*

## APPENDIX D: State Use of Waivers and Demonstration Authority Pre-ACA

State Use of Waivers. The Vermont Medicaid program illustrates the type of projects that are permissible under an approved Section 1115 waiver. In fall of 2005, Vermont secured approval for a Section 1115 Medicaid waiver, known as the “Global Commitment Waiver,” that imposes a cap on the amount of federal Medicaid funding available to Vermont to provide acute care services.<sup>150</sup> The waiver allows the state to establish itself as a public managed care company.<sup>151</sup> As such, it will pay itself a premium for each beneficiary that it serves. If the state can deliver care for less than the premium revenue, it can use the excess revenue for a broad array of purposes. Within limits, the state controls the amount it pays itself, which means it can ensure that excess premium revenue arises by paying (with the assistance of federal matching funds) more than needed to operate its Medicaid program.

In addition, Vermont implemented a Section 1115 Medicaid waiver program that made fundamental changes to how it provides long-term services and supports to low-income seniors and people with disabilities. Called “Choices for Care,” this waiver also established the state as a managed care organization allowing it to pay itself a premium for each beneficiary that it serves.<sup>152</sup> It permits the state to use federal Medicaid funds for state fiscal relief and non-Medicaid health programs.

State Demonstrations. North Carolina handles their dual eligible population through Community Care of North Carolina (CCNC). CCNC is the traditional managed care model for North Carolina’s Medicaid program.<sup>153</sup> As of 2011, CCNC runs 14 networks with 1,400 primary care medical homes that serve 1 million Medicaid recipients.<sup>154</sup> In 2006, the North Carolina General Assembly instructed CCNC to extend its managed care system to dual-eligible individuals:<sup>155</sup> as such, CCNC established an initial partnership with CMS that same year to run a Medicare Health Care Quality Demonstration (646 demonstration). The North Carolina General Assembly further directed CCNC carry out a program that “combines a physician-directed care management approach with the use of health information technology (HIT) to connect providers, support care management and delivery, measure performance, and implement pay-for-performance financial

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<sup>150</sup> JOCELYN GUYER, KAISER FAMILY FOUNDATION, VERMONT’S GLOBAL COMMITMENT WAIVER: IMPLICATIONS FOR THE MEDICAID PROGRAM, (2006) *available at* <http://www.kff.org/medicaid/upload/7493.pdf>.

<sup>151</sup> The Medicaid managed care organization requirements are contained at Part 438 of Title 42 of the Code of Federal Regulations.

<sup>152</sup> JEFFREY S. CROWLEY & MOLLY O’MALLEY, KAISER FAMILY FOUNDATION, VERMONT’S CHOICES FOR CARE MEDICAID LONG-TERM SERVICES WAIVER: PROGRESS AND CHALLENGES AS THE PROGRAM CONCLUDED ITS THIRD YEAR (2008) *available at* <http://www.kff.org/medicaid/upload/7838.pdf>.

<sup>153</sup> STEPHEN WILHIDE & TIM HENDERSON, AMERICAN ACADEMY OF FAMILY PHYSICIANS, COMMUNITY CARE OF NORTH CAROLINA: A PROVIDER-LED STRATEGY FOR DELIVERING COST-EFFECTIVE PRIMARY CARE TO MEDICAID BENEFICIARIES (2006) *available at* [http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/policy/state/medicaid/ncfull.Par.0001.File.tmp/ncfullreport.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/state/medicaid/ncfull.Par.0001.File.tmp/ncfullreport.pdf).

<sup>154</sup> Torlen Wade, Eileen Ciesco & Angela Floyd, *An Update on Community Care of North Carolina’s Medicare Demonstrations*, 72 N.C. MED. J. 225 (2011).

<sup>155</sup> Torlen Wade, *The Medicare Health Care Quality Demonstration Program: The Promise and Opportunity of the 646 Waiver*, 70 N.C. MED. J. 245 (2009).

incentives.”<sup>156</sup> The demonstration officially began in 2010 and is slated to run for a five-year period.<sup>157</sup> It is estimated that during the first two years of the demonstration, CCNC will manage 42,000 dual-eligible individuals through 196 CCNC practices in 26 counties.<sup>158</sup> This will expand during the third year, when CCNC will add 170,000 Medicare-only beneficiaries, eventually managing approximately 212,000 Medicare-only and dual eligible individuals by the end of the demonstration.<sup>159</sup>

SNP Model. Rhode Island provides a good examples of the use of SNPs to manage care for dual eligibles. In January of 2006, BlueCross & BlueShield of Rhode Island, a nonprofit Medicare managed care plan, partnered with Neighborhood Health Plan of Rhode Island, the state’s largest Medicaid managed care plan, to offer a Medicare dual eligible Special Needs Plan to Rhode Islanders. BlueCross manages the contract with CMS and provides administrative services, enrollment, provider contracts, underwriting, etc., while Neighborhood Health Plan coordinates care management and customer services.<sup>160</sup>

As the Rhode Island Medicaid program does not offer Medicaid managed care for dual eligibles, the SNP does not have a contract with the state to serve the dual-eligible population and does not receive a Medicaid payment from the state. However, in addition to the SNP plan offering all services under Medicare Parts A, B and D, it still coordinates services provided by Medicaid through its care management program. Thus, the SNP assists members in finding access to covered Medicaid services and to maintain Medicaid eligibility. Additionally, the plan offers benefits on top of those provided by Medicare, including transportation, dental coverage, and enhanced care coordination services.

Multi-Program Models. California uses both PACE and SNPs to deliver care. Approximately 83% of California’s dual eligible population remains in Medi-Cal Fee-For-Service arrangements. For the other 17%, Medi-Cal offers a voluntary managed care approach through a few different organizations. PACE is a comprehensive approach to care that integrates Medicare and Medi-Cal financing to provide necessary preventive, primary, acute and long-term care needs for dual eligibles. To qualify for PACE, a beneficiary must be eligible for nursing home level of care. PACE began as a waiver demonstration in the 1980s, but has since become option as part of the Balanced Budget Act of 1997. Eligible individuals may also enroll in the SCAN Health Plan.<sup>161</sup> SCAN originally started as a social HMO demonstration, but now is a Medicare Advantage Prescription Drug Plan with a SNP designation for the dual eligible population. SCAN contracts with the DHCS to provide full scope Medicare and Medi-Cal services for senior dual eligibles. To be eligible for SCAN, an individual must be at least 65, have Medicare Parts A and B, have

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<sup>156</sup> *Id.*

<sup>157</sup> Wade, Ciesco & Floyd, *supra* note 153.

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> ELLEN LUKENS, LISA MURPHY & JON BLUM, AVALERE HEALTH , MEDICARE ADVANTAGE SPECIAL NEEDS PLANS – SIX PLANS’ EXPERIENCE WITH TARGETED CARE MODELS TO IMPROVE DUAL ELIGIBLE BENEFICIARIES’ HEALTH AND OUTCOMES (2007) available at [http://www.avalerehealth.net/research/docs/ACAP\\_Medicare\\_Needs\\_Plans.pdf](http://www.avalerehealth.net/research/docs/ACAP_Medicare_Needs_Plans.pdf).

<sup>161</sup> MELANIE BELLA, ALICE R. LIND & STEPHEN A. SOMERS, CENTER FOR HEALTH CARE STRATEGIES, OPTIONS FOR INTEGRATED CARE FOR DUALS IN MEDI-CAL: THEMES FROM INTERVIEWS WITH KEY INFORMANTS AND COMMUNITY DIALOGUES (2010) available at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261128](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261128).

full scope Medi-Cal with no share-of-cost, and live in SCAN's approved service areas of Los Angeles, Riverside, and San Bernardino counties.<sup>162</sup>

California has the largest enrollment of duals in Medicare SNPs among all states. In addition to SCAN Health Plan, SNPs include County Organized Health Systems (COHS) and Two-Plan county programs. A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program. Under a Two-Plan county program, Medi-Cal contracts with two managed care health plans in a county; one established commercial health care plan, and a locally organized "local initiative" health care plan. COHS and Two-County only offer either partially managed services for Medi-Cal benefits, or management of Medicare services alone if an SNP.<sup>163</sup>

California is continuing to move forward with new models. In 2010 California passed SB208, which directs DHCS to develop integrated care pilots for dual eligibles in four counties.<sup>164</sup> California was awarded a State Innovation Grant under the ACA to finance the effort.

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<sup>162</sup> Issue with Dual Eligible Members Enrolled in the Senior Care Action Network (SCAN) Health Plan, State of California Health & Human Services Agency, (issued Mar. 9, 2011) *available at* <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-12.pdf>.

<sup>163</sup> Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare, State of California Health & Human Services Agency (issued Apr. 29, 2011) *available at* [http://www.dhcs.ca.gov/provgovpart/rfa\\_rfp/Documents/DualEligM-C+Mcare.pdf](http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/DualEligM-C+Mcare.pdf).

<sup>164</sup> ADAM DOUGHERTY, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, COST CONTAINMENT STRATEGIES FOR CALIFORNIA'S DUAL ELIGIBLE POPULATION (2011) *available at* [www.itup.org/Reports/Dougherty,A\\_Duals\\_Strategies.pdf](http://www.itup.org/Reports/Dougherty,A_Duals_Strategies.pdf).

## **APPENDIX E: Additional Provisions of the ACA that Affect Dual Eligible Individuals**

### ***Center for Medicare and Medicaid Innovation (Innovation Center)***

In developing payment and service delivery models for testing, the ACA directs the Secretary to “give preference to models that also improve the coordination, quality and efficiency” of care for Medicare beneficiaries, Medicaid beneficiaries, and dual eligibles.<sup>165</sup> The models establish a two-phase testing period for the demonstrations. During Phase I, the Secretary must choose health care delivery models where the Secretary determines there is “evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures” and specify a focus on models that are expected to “reduce program costs. . . while preserving or enhancing the quality of care. . . .”<sup>166</sup> Provisions that specifically address care for dual eligible individuals direct the Secretary to allow states to “test and evaluate fully integrating care for dual eligible individuals” including the “management and oversight of all funds” under Medicare and Medicaid.

The Secretary may expand the model to Phase II if the model meets one of the following goals: 1) the Secretary determines that the expansion is expected to reduce spending without reducing the quality of care or improve the quality of patient care without increasing spending, 2) the Chief Actuary for CMS certifies that the expansion would reduce or would not result in any increase in net program spending under Medicare and Medicaid, and 3) the Secretary determines that the expansion would “not deny or limit the coverage or provision of benefits” to Medicare or Medicaid beneficiaries.<sup>167</sup>

The ACA also establishes additional factors that the Innovation Center “may consider” in selecting models, specifically, whether the model, including processes for monitoring and updating patient care plans, placing beneficiaries, family members and other informal caregivers at the “center of the care team; use of technology, team-based approaches, the ability to share information on a real time basis; and those that demonstrate “effective linkages” with other public and private sector payers.<sup>168</sup> Unlike traditional demonstrations, models do not have to demonstrate that they are initially budget neutral.<sup>169</sup>

### ***Medicare Shared Savings Program***

The ACA authorized a model of care delivery under Medicare through which a group of providers may voluntarily assume responsibility for the delivery of services under Medicare parts A and B for a defined patient population.<sup>170</sup> These organizations, known as accountable care organizations (ACOs), will receive compensation through an arrangement that combines traditional fee-for-service payments with financial incentives to reduce costs, improve quality,

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<sup>165</sup> ACA § 3021(a).

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> ACA §3022.

and achieve greater information transparency. CMS would share savings associated with improved quality and efficiency with ACO participants. CMS estimates that over the three-year period beginning in 2012, ACOs will save an estimated \$510 million and will involve 75-150 ACOs delivering care to between 1.5 million and 4 million Medicare beneficiaries.<sup>171</sup>

### ***Medical and Health Homes under Medicare and Medicaid***

Among the models suggested for testing under authority granted to the Innovation Center, are "broad payment and practice reform in primary care, including patient-centered medical home models for high-need Medicare and Medicaid beneficiaries, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive or salary based payment."<sup>172</sup> The Secretary has announced a new demonstration making up to \$42 million available to federally qualified health centers (FQHCs) to develop medical homes for up to 195,000 Medicare-eligible individuals<sup>173</sup> FQHCs will coordinate care for Medicare-eligible individuals, including dual eligibles. CMS and the Health Resources Services Administration (HRSA) will jointly administer the 3-year demonstration.<sup>174</sup>

### ***Changes Affecting Waivers***

The ACA also included a provision designed to extend certain Medicaid demonstration programs. Specifically, the law permits CMS to approve Medicaid demonstration projects that involve dual eligible individuals for a period of 5 years.<sup>175</sup> If a state requests an extension of the waiver at the end of the 5 year period, the Secretary must extend the waiver, unless the waiver conditions were not met or would no longer be cost-effective and efficient, or consistent with the purpose of the waiver.<sup>176</sup>

### ***Duals Demonstrations Announcement***

CMS has selected 15 states to participate in demonstration projects to implement "person-centered models that fully coordinate primary, acute, behavioral and long-term supports and services for dual eligible individuals." Working through the Innovation Center, CMS awarded up to \$1 million to each of the 15 states, which include: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South

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<sup>171</sup> Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19528, 19635 (proposed April 7, 2011) (to be codified at 42 C.F.R. pt. 425).

<sup>172</sup> ACA §3021.

<sup>173</sup> See Center for Medicare & Medicaid Innovation, Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/fqhc/> (last visited Oct. 27, 2011).

<sup>174</sup> *Id.*

<sup>175</sup> ACA §2601.

<sup>176</sup> *Id.*

Carolina, Tennessee, Vermont, Washington and Wisconsin.<sup>177</sup> Of these states, Massachusetts, Minnesota, New York and Washington have operated fully integrated models through SNPs or PACE.<sup>178</sup>

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<sup>177</sup> Press Release, U.S. Department of Health and Human Services, New flexibility for states to improve Medicaid and implement innovative practices (Apr. 14, 2011) *available at* <http://www.hhs.gov/news/press/2011pres/04/20110414a.html>

<sup>178</sup> JUNE 2011 MEDPAC REPORT *supra* note 68.