

Supporting Alternative Integrated Models for Dual Eligibles: A Legal Analysis of Current and Future Options

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Foreword

Among the most pressing health care reform issues likely to be left for future policy debate is how to advance integration of care for those who are eligible for both Medicare and Medicaid (“dual eligibles”). Ironically, these beneficiaries—arguably those most in need of integrated care—are the ones most likely to be in fragmented fee-for-service systems of care. The resulting costs, in terms of both poor health outcomes and excessive spending, are enormous. Unfortunately, existing policies, as embodied in current federal law, regulation, and administrative and financing practices, present myriad barriers to innovations in care at the state and local levels.

The Center for Health Care Strategies, Inc. (CHCS) turned to its expert colleagues at George Washington University’s Department of Health Policy (GW) to conduct an analysis of the current legal and regulatory barriers and possible avenues for working within them (and/or around them) to integrate care for dual eligibles. While special needs plans (SNPs) authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) have significant potential for integrating care, much has already been written about SNPs as a vehicle to pursue integration.

Thus, this inquiry focuses on alternative vehicles for achieving integration. CHCS thanks The Commonwealth Fund for underwriting this project. Further, we thank *Sara Rosenbaum, Jane Hyatt Thorpe, and Sara Schroth* at GW for preparing this analysis so quickly—perhaps some of their ideas may be taken up sooner rather than later by those in Congress and the Obama Administration crafting future health care.

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As health care costs in the United States continue to escalate, policymakers will have to pay more attention to individuals who are dually eligible for both Medicare and Medicaid. Although they are relatively small in number (8.8 million), dual eligible beneficiaries tend to experience higher rates of poor health and continuous needs, making them a very expensive population.¹ In 2005, dual eligible beneficiaries accounted for an estimated \$215 billion in federal and state spending.² This represents almost 25 percent of total Medicare spending and 46 percent of Medicaid spending.³ Moreover, the combination of poor health status and low incomes makes dual eligibles highly dependent on the two public programs for the care they need.

To address the needs of dual eligibles within the constraints of tightening budgets, several states have developed models to closely integrate Medicare and Medicaid benefits and funding. One such option has been through special needs plans (SNPs), which are private plans that may be available to beneficiaries in any of three categories—those who are dual eligibles, have severe or disabling chronic conditions, or are institutionalized—through the Medicare Advantage (MA) program. While SNPs offer a useful vehicle that, at a minimum, allows integration of Medicare and Medicaid funding at the plan level, this option has been plagued by uncertainties, including a previous moratorium on new SNPs and uncertain prospects due to program authorization that expires in December 2010.

This brief examines statutory, regulatory, and administrative opportunities for integration of Medicare and Medicaid funding outside of SNPs.⁴ It begins with background regarding the laws and regulations that govern the Medicare and Medicaid programs specific to dual eligibles. It then describes the barriers these laws and regulations pose to the integrated delivery and reimbursement of care for dual eligible beneficiaries. It concludes with a look at opportunities for administrative or legislative changes,

including the realignment of disincentives through the use of joint Medicare/Medicaid demonstration authority, to foster integration while permitting Medicare and Medicaid to share in any savings. These opportunities are grouped into three categories: (I) Current State Plan Options and Potential Approaches to Health System Improvement; (II) Achieving Integration through Current and Potential Demonstration and Waiver Authorities; and (III) Options for Legislative Consideration.

Background: Medicare and Medicaid Coverage and Service Delivery for Dual Eligibles

Medicare and Medicaid are legally structured to operate as two separate programs; moreover, there is little or no financial incentive to integrate services for beneficiaries who are enrolled in both. On the Medicaid side of the equation, states have little incentive to improve coverage, build integrated delivery systems, or utilize higher payment rates, because potential savings would accrue primarily to Medicare, with no opportunity for Medicaid to share in those savings. On the Medicare side, the legal and financial incentives are directed toward shifting costs when possible into Medicaid.

Coverage. Although the Medicare and Medicaid programs were designed for distinct purposes, there is significant overlap among the eligible populations, and responsibility for financing the long-term care needs of low-income elderly and disabled beneficiaries falls to Medicaid. Each program is governed by different statutory authority, resulting in separate requirements regarding benefits and services, coverage standards, conditions of provider participation, provider payment, and methods of administration. Statutory differences in the two programs are evident particularly with respect to coverage. For example, Medicare’s medical necessity standard that covers 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”⁵ is restorative in nature, resulting in thousands of claims denials for treatments and services that do not support clinical improvement. Medicaid, on the other hand, allows payment for treatments and services that avert further deterioration and enable maintenance of current functioning, even if functioning cannot “improve” in a clinical sense.⁶

Because Medicaid allows payment for services that avert deterioration and loss of functioning, it is possible to finance treatments and services that maintain patient status, thereby avoiding acute episodes that result in high Medicare hospitalizations and churning readmissions. If states used the

broader authority recognized under federal Medicaid law to expand Medicaid coverage for dual eligible beneficiaries, it might be possible to avert significant acute care costs for Medicare (although again, Medicaid would not receive any of these savings).

Payment System. The relationship between Medicare and Medicaid coverage for dual eligible beneficiaries is further complicated by their distinct and separate payment systems. In general, the Social Security Act only expressly authorizes the Secretary of the Department of Health and Human Services (HHS) to make payments for Medicare-covered services to providers, suppliers, Part D plans, and MA plans.⁷ State Medicaid agencies are not included in the definitions of these terms, nor is there any other express authorization for the Secretary to pay state Medicaid agencies for Medicare services unless they meet the requirements of one of the authorized payment categories (e.g., suppliers, MA plans) or such payments are made pursuant to a demonstration or waiver authority.

In the case of dual eligible beneficiaries, there are numerous potential approaches to Medicare and Medicaid coverage and payment, each of which could carry its own requirements. At one end of the spectrum are traditional fee-for-service (FFS) arrangements that result in fragmented financing between the two programs and that lack an overall entity responsible for coverage and payment. For example, dual eligibles can receive Medicare services either on a FFS or managed care basis (i.e., through Medicare Advantage plans); similarly, Medicaid services are typically also available through either a FFS or managed care arrangement. This creates a variety of coverage and payment models for dual eligibles, none of which are integrated. Adding to the complexity is the fact that dual eligibles may also receive prescription drugs through stand-alone Medicare prescription drug plans. In fact, the vast majority of dual eligibles, more than 80%, receive acute care through the traditional Medicare FFS program, prescription drugs through stand-alone Medicare Prescription Drug Plans,⁸ and additional acute care and long-term care services through Medicaid FFS.

At the other end are coverage and financing models that assume a higher level of financial and clinical integration. There are a few situations in which Medicare and Medicaid funding are integrated and care is managed by a single entity: (1) when the beneficiary is enrolled in a SNP that also holds a Medicaid contract; and (2) when the beneficiary is enrolled in the Program for All-Inclusive Care for the Elderly (PACE). Regardless of whether a Medicare beneficiary is served in Medicare FFS or through MA, Medicare is the primary insurer, with Medicaid covering and paying for items

and services not covered by Medicare or that exceed Medicare's limits.

Finally, some dual eligibles receive care through state waiver programs that allow states to provide additional services or modify payment arrangements that better meet the needs of dual eligible populations. The laws governing these programs do not require any integration between them, and in many cases, may work to inhibit integration.

Providers. Medicare and Medicaid are both voluntary programs for providers. Providers that choose to participate in Medicare and Medicaid must agree to certain terms that are specific to each program. For example, Medicare providers must agree to accept as payment in full the Medicare payment amount for services provided to Medicare beneficiaries.⁹ However, there is no requirement that a Medicare provider also participate in Medicaid, or vice versa. This separation of Medicare and Medicaid effectively was reinforced by the Balanced Budget Act of 1997 (BBA), which allows state Medicaid agencies to limit cost sharing assistance for dual eligible beneficiaries to the Medicaid payment rate.¹⁰ States are thus exempt from payment of Medicare cost sharing if the Medicare payment level, minus the copayment, meets or exceeds what the state would have paid under Medicaid for the same service. Since state Medicaid payment rates tend to fall well below the Medicare level, particularly when coinsurance and deductibles are taken into account,¹¹ the effect of the BBA has been to disincentivize Medicaid participation among Medicare providers.¹²

Administrative and Legislative Options for Integrating Medicare and Medicaid Funding and Services for Dual Eligibles

Policymakers and researchers agree that better integration between Medicare and Medicaid would support greater coordination of care to dual eligible beneficiaries while also leading to improved quality and cost effectiveness and efficiency.¹³ However, as discussed above, the Medicare and Medicaid programs operate under separate laws that in numerous ways can impede financial and clinical integration. In recent years increased attention has been paid to models that better coordinate Medicare and Medicaid funding streams and coverage; at the same time, there are additional options that might be considered in order to yield even better results. Some of these options are administrative in nature, meaning the Secretary of Health and Human Services (HHS), acting through the Centers for Medicare and Medicaid Services (CMS), could implement the proposed model under current law and without new

legislation. Other options are legislative in nature, meaning that they would require additional legislation authorizing the Secretary to act.

I. Current State Plan Options and Potential Approaches to Health System Improvement

Existing law suggests two possible pathways (either separately or simultaneously) to better integrate funding and care for dual eligible beneficiaries: (a) encourage states to use existing authority under federal law to develop systems of care that result in greater quality and efficiency for beneficiaries; and (b) make greater use of the HHS Secretary's demonstration authority to develop targeted clinical and financial integration initiatives. (For more detailed explanation of current demonstration, statutory, and waiver authority available within the Medicare and Medicaid programs, see the Appendix.) The central goal in both options is to advance quality and cost effectiveness through clinical and financial integration of services and financing available under both programs. In some states, this may mean developing integrated service delivery systems that can partner with both state Medicaid programs and Medicare. In others, the approach may involve the Medicaid program itself acting as the administrator of clinical care delivery arrangements, thereby coordinating payment, coverage, and benefits. In the operational sense, these types of advances parallel the growth of Medicaid managed care. That is to say, they reflect the concept of integration of both financing and care as a means of promoting the access, quality, and stability of care, as well as operational efficiency.

States have a series of existing options for developing integrated care delivery arrangements for dual eligible beneficiaries:

1. Section 1903(m), Section 1932, and Section 1937 Authority. States can use Section 1903(m) (federal requirements for managed care organizations) and Section 1932 authority to develop voluntary managed care systems for dual eligibles. These systems would have the ability to participate in both Medicare and Medicaid; administer both programs; develop provider networks; coordinate care across a range of preventive, acute care, and chronic care conditions; and incorporate health information, quality improvement, and system performance measurement and monitoring for enrollees. While enrollment is voluntary for dual eligibles, CMS in the past has indicated a willingness to treat an approach that uses automatic enrollment with the right to opt-out as meeting the voluntary enrollment requirement.¹⁴ Section 1932 would allow states to experiment with different payment approaches including full

capitation, case payments using episodes of care and fee for service payments, and other approaches. In other words, nothing in the law limits Section 1932 to fully capitated arrangements.

Furthermore, Section 1937 of the Social Security Act, which waives statewideness and comparability for certain types of coverage arrangements, might be used by states to augment benefits for dually eligible populations enrolled in managed care entities (including state-administered entities).¹⁵ Section 1937 permits states to provide “benchmark” or “benchmark-equivalent” benefits to one or more state populations representing current enrollee classes. A highly enriched benchmark equivalent coverage plan, with additional benefits for dual eligibles beyond what they might receive on a FFS basis, would permit a state to incentivize initial enrollment and/or a beneficiary’s decision to remain enrolled in an “opt-out” situation.

These authorities would also allow a state to act as its own managed care entity. By taking advantage of its authority under Sections 1903(m), 1932, and 1937 (if additional benefits are to be furnished), a state would be able to self administer a plan for dual eligible beneficiaries. The state in effect would take on plan responsibilities that otherwise would be assigned to managed care entities, such as network development and selection, provider payment and performance review, financial administration, administration of enrollee protections, care management functions, health information collection and use, and compliance with other safeguards. Thus, through CMS approval of states using automatic enrollment coupled with opt-out rights as well as the authority of states to act as managed care entities, a state Medicaid agency could conceivably satisfy applicable requirements to act as a managed care system that can achieve full financial and clinical integration.

2. Flexible PACE Model. Federal Medicaid law also permits states to develop contracts with PACE providers.¹⁶ States can contract with a PACE organization or administer a PACE program, thereby advancing the goal of integrated, high-quality health care as described above.

In sum, whether undertaken as a managed care or PACE initiative, on either a purchased (e.g., through a contract with a managed care entity) or self-administered basis, either model would permit a state to pursue clinical and financial integration within the “four corners” of the Medicaid program on behalf of dual eligibles. If CMS combined its approval of automatic enrollment and voluntary opt-out with clarification of the circumstances under which a state, acting as a plan administrator, could receive Medicare fee-for-

service payments and coordinate coverage and payment over the provider network, it would be possible for a state to pursue clinical and financial integration *within* Medicaid in a manner that also integrates Medicare financing.

II. Achieving Integration through Current and Potential Demonstration and Waiver Authorities

While existing state plan options limit coverage to voluntary enrollment (and automatic enrollment with opt-out rights), Social Security Act demonstration and waiver authority might be used to establish compulsory enrollment arrangements in purchased or administered delivery systems that are capable of achieving both clinical integration and the integration of Medicare and Medicaid financing as well as their service, benefit, and performance provisions.

Three basic demonstration authorities exist:

1. Section 1115 Demonstration Authority – Allows states to expand coverage to new groups of people, modify the delivery system, or change the benefit package design, and importantly, allows states to require eligible beneficiaries to participate in the program.¹⁷

2. Section 402 Demonstration Authority – Allows secretary to engage states in demonstrating new approaches to provider reimbursement, delivery systems, and coverage of additional services to improve the efficiency of Medicare.¹⁸ Section 402 may be broad enough to permit the Secretary to allow states to implement approaches that integrate Medicare and Medicaid funding and services and include mandatory enrollment.

3. Section 1915 (a)-(c) Waiver Authority – Section 1915 (a)–(b) allows states to develop managed care programs on a statewide or in limited geographical areas with either voluntary enrollment (Section 1915(a)) or mandatory enrollment (Section 1915(b)). Section 1915(c), often coupled with Section 1915(b) authority, authorizes states to provide long-term care services delivered in community settings as an alternative to institutional care.

Using Sections 1915 and 1115, states have been able to achieve clinical and financial integration within Medicaid for special populations. Section 1915 authority by itself would not appear to allow the integration of Medicare financing, but one option may be the use of Section 1115 demonstration authority by the Secretary to add Medicare integration to states that have been able to successfully create integrated Medicaid delivery arrangements for special populations under Section 1915. Section 1115 does not

authorize the Secretary to waive provisions of Medicare that might otherwise restrict states from being considered eligible to receive Medicare payments directly, but Section 1115 would allow the Secretary to address provisions of Medicaid law that might be considered as posing legal barriers to clinical and financial integration for dual eligibles.

Under longstanding policy, Medicaid and Medicare waivers must be budget neutral to the federal government as determined by the Office of Management and Budget (OMB) with advice from the CMS Office of the Actuary. This OMB policy is not required by statute or regulation, but rather is policy that has been in place to protect the fiscal integrity of the program.¹⁹ The state applying for the waiver must demonstrate that federal Medicaid expenditures with the waiver program will not exceed what the federal Medicaid expenditures would have been in the absence of the waiver program. Furthermore, in determining budget neutrality, the waiver request may not use projected federal savings in one program (e.g., Medicare) to offset projected higher spending in the other (e.g., Medicaid)—again, this is a longstanding policy surrounding Medicare and Medicaid waivers that is required neither by law nor regulation. The savings that may accrue to Medicare through an integrated model for dual eligibles therefore cannot, at this point, be considered to offset potentially increased costs for state Medicaid agencies to develop an integrated care program for dual eligibles—even if total federal spending is expected to be reduced. The Secretary and OMB might consider revisiting this policy in the context of dual eligibles. If OMB were to change its policy, potential Medicare savings flowing from reduced hospitalization or extended care costs could be considered in the calculation of budget neutrality for Medicaid. This would be an important incentive for states that also could yield reduced overall costs related to the treatment and management of dual eligibles.

III. Options for Legislative Consideration

There are a number of reform options currently being considered by Congress, including one that creates opportunities for CMS to test innovative payment models for Medicare and Medicaid.²⁰ This new demonstration authority, if included in the final legislation, greatly expands authority to design new payment and care delivery models for dual eligibles, including integrated models. Other more specific options could include:

1. *Shared Savings and Medical Home Demonstrations.*

Expand opportunities for Medicaid shared savings and medical home demonstrations. For example, North Carolina is currently experimenting with an integrated model for dual

eligible beneficiaries through a demonstration program authorized by Section 646 of the Medicare Modernization Act.²¹ Under this demonstration, a group of community care networks that currently serve North Carolina's Medicaid-only, low-income, and uninsured populations will expand to coordinate care for dual eligible and Medicare-only populations.²² This coordinated effort operates under a shared savings model agreement with the federal government, in which a portion of any cost savings resulting from better care management and coordination of dual eligible or Medicare-only patients will be shared between the federal government and the state. North Carolina is planning to use its share of savings to facilitate expansion of the community care network and to enhance other state quality improvement and cost containment initiatives.²³

This type of shared savings approach may be useful for other states as well, particularly those that provide a significant portion of their Medicaid benefit under a FFS-based primary care case management (PCCM) program. Legislation could require expansion of shared savings demonstrations to additional states or permanently authorize these types of programs.

The shared savings model also presents opportunities in the context of the current move toward development and implementation of medical homes. State Medicaid programs could be incentivized to pursue medical home demonstrations under Section 1115 waiver authority. Savings accruing to the state Medicaid program through this type of gainsharing approach could be used to provide supplemental benefits to dual eligibles. Congress could also require that Medicare and Medicaid funding be integrated through medical homes that would be managed by state Medicaid programs to foster greater coordination of care for this population.

2. *PACE Expansion.* While growth in the PACE program has been more limited than anticipated, this could be addressed through legislative changes that: (a) authorize the development of a new capitated program specifically designed for dual eligible beneficiaries; or (b) remove some of the barriers that have slowed the growth of PACE. This might include: (a) expanding the populations that are eligible for PACE; (b) reducing geographic limitations; or (c) enhancing the Medicare capitated payment for states that encourage providers to become PACE programs and/or current PACE providers to expand their programs.

3. *Compulsory Enrollment.* Currently, all dual eligible beneficiaries enrolled in Medicaid managed care must be voluntarily enrolled. This has resulted in small numbers of

This policy brief and CHCS' ongoing efforts with states and CMS to support integrated care for dual eligibles are made possible through support from The Commonwealth Fund.

consumer protections and safeguards) without a waiver, as discussed above, and potentially both reduce spending and increase benefits. In addition, legislation could require the Secretary to share any Medicare savings that might result from the increased enrollment with the states, providing an upfront financial incentive for states to pursue initiatives that lead to improved system-wide efficiency.

Conclusion

Integrating care for dual eligibles represents a critical, and largely untapped, opportunity to improve care and control Medicaid costs for an exceedingly high-need population. While in many states SNPs offer a viable

dual eligibles enrolled in Medicaid managed care, even for those enrolled in an MA plan. If the ban on compulsory enrollment were lifted, states could make managed care coverage more workable as a state plan option (with appropriate

mechanism for dual eligible integration, capitated managed care is not feasible in every state or region. This brief offers a variety of options to support integration, including alternatives that can be implemented under existing policy as well as new approaches that are worth considering at the federal level. For example, modifying PACE may offer states a new avenue for integrating care using a policy and programmatic framework that has already proven to be successful. More analysis needs to be done to determine exactly how PACE could be modified to meet broader integration goals.

It is important to note that the options presented here are not exclusive. CMS could issue guidance for voluntary enrollment models under existing state options, while at the same time pursuing selected demonstration authorities. In addition, if health reform broadens demonstration authority, special integrated delivery demonstrations could ultimately become a specific focal point of CMS activity around dual eligible beneficiaries. For states eager to integrate care for dual eligibles, there arguably has never been a better—or more important—time to pursue innovative models.

Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS is working with states, health plans, and federal policymakers to develop and support programs that integrate care for adults who are dually eligible. To learn about CHCS' *Transforming Care for Dual Eligibles* initiative or to download resources from *Designing Integrated Care Programs: An Online Toolkit*, visit www.chcs.org.

Endnotes

¹ Teresa Coughlin, Timothy Waidmann, and Molly O'Malley Watts. *Where Does the Burden Lie?: Medicaid and Medicare Spending for Dual Eligible Beneficiaries*, Kaiser Family Foundation, 2009. Available at www.kff.org/medicaid/upload/7895-2.pdf.

² Center for Health Care Strategies, *Supporting Integrated Care for Dual Eligibles: Policy Options*, July 2009. Available at www.chcs.org/publications3960/publications_show.htm?doc_id=982564.

³ J. Holahan, D. M. Miller, and D. Rousseau. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005." Kaiser Commission on Medicaid and the Uninsured, February 2009.

⁴ Given that significant attention has already been placed on the use of SNPs as a vehicle for integrating care, this brief focuses on alternative integration models. However, it is important to note that there are a number of opportunities for improving the use of SNPs for integration, some of which are being discussed as part of broader health reform (e.g., a requirement that all SNPs contract with states to coordinate Medicare and Medicaid services and funding for dual eligibles, not just those expanding their service areas as required by the Medicare Improvements for Patients and Providers Act of 2008).

⁵ Social Security Act § 1863(1)(A) codified at 42 U.S.C. § 1395z (2006).

⁶ 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. Certain Medicaid benefits are governed by medical necessity tests embedded directly into the benefit class itself.

⁷ 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).

⁸ Center for Health Care Strategies, op. cit.

⁹ Stuart Guterman, Karen Davis et al. *Using Medicare Payment Policy to Transform the Health System: A Framework for Improving Performance*, Health Affairs, 2009; (28)2: w238-w250.

¹⁰ Pub. L. 105-33 § 4714 (1997).

¹¹ Stephen Zuckerman, Aimee Williams et al. *Trends In Medicaid Physician Fees, 2003–2008*, Health Affairs, 2009; 28(3):w510-w519.

¹² MedPAC Report to Congress, *Dual Eligible Beneficiaries: An Overview*, Ch. 3, June 2004. Available at

www.medpac.gov/publications/congressional_reports/June04_ch3.pdf.

¹³ See, e.g., The Centers for Medicare and Medicaid Services' ("CMS") Integrated Care Initiative provides that "the overall goal of integrated care is to provide the full array of Medicare and Medicaid benefits through a single delivery system that will provide quality of care for dual eligible beneficiaries, better care coordination and fewer administrative burdens." See also Center for Health Care Strategies, *Supporting Integrated Care for Dual Eligibles: Policy Options*, op. cit.

¹⁴ Examples of automatic enrollment with opt-out rights include the Medicare Part D and the Wisconsin “all-in/opt out” approach. See also CMS Medicaid Director Letter (March 31, 2006) permitting voluntary enrollment into benchmark coverage and the use of voluntary opt-out systems. Available at www.cms.hhs.gov/smdl/downloads/SMD06008.pdf.

¹⁵ 42 U.S.C. § 1396u-7 (2006).

¹⁶ 42 U.S.C. § 1396u-4 (2006).

¹⁷ 42 U.S.C. § 1315 (2006). For example, Vermont is using an 1115 waiver to establish itself as a public managed care entity, using capped Medicaid funding to provide services to its eligible Medicaid population and savings generated to expand the program or support other related purposes. See Jeffrey S. Crowley and Molly O'Malley, *Vermont's Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded its Third Year*, Henry J. Kaiser Family Foundation, November 2008. Available at www.kff.org/medicaid/upload/7838.pdf. States also may consider use of Section 1110 demonstration authority (42 U.S.C. § 1310 (2006)) for Supplemental Security Income (SSI) recipients since many dual eligible beneficiaries are also SSI recipients. Section 1110 authorizes pilots to improve the administration and effectiveness of the Medicare, Medicaid, and SSI programs as well as jointly financed cooperative arrangements with states to conduct related research.

¹⁸ 42 U.S.C. § 1395b-1 (2006); See also Social Security Act Vol. II, Pub. L. No. 90-248 § 402(a); Pub. L. No. 92- 603 § 222(b). 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).

¹⁹ United States Department of Health and Human Services, Office of Budget, *Plan for Improvement in the GAO High-Risk Area of Medicaid*, July 2008. Available at www.hhs.gov/budget/medicaidplan.html.

²⁰ Current legislative language included in an amendment to the House Tri-Committee bill (H.R. 3200) as well as the Senate Finance Committee bill authorizes the creation of a Center for Medicare and Medicaid Payment Innovation and Center for Innovation respectively (both within CMS).

²¹ Torlen Wade. *The Medicare Health Care Quality Demonstration Program: The Promise and Opportunity of the 646 Waiver*, NCMed J May/June 2009, Volume 70, Number 3, 245-247, Available at www.ncmedicaljournal.com/May-Jun-09/Wade.pdf.

²² Ibid; see also Engelberg Center for Health Care Reform at Brookings, Issue Brief: State Health Reform Series, October 2008, Available at www.brookings.edu/health/~media/Files/events/2008/1008_health_reform/1008_health_reform.pdf.

²³ T. Wade, op. cit.

Appendix: Current Authority Options for Integrating Care for Dual Eligible Beneficiaries

Demonstration Authority	
Medicare	<p>Section 646: Section 646 of the MMA authorized Medicare Health Care Quality Demonstration Programs thereby establishing five-year demonstration programs to expand the physician group practice demonstration model and evaluate models to foster greater care coordination and disease management. 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.</p> <p>State Example: North Carolina</p>
Statutory Authority	
Medicare	<p>Special Needs Plans: SNPs were designed to address the needs of three special populations including dual eligibles. Specifically, the MMA authorized Medicare to pay a SNP a capitated amount to manage the care covered and reimbursable under Medicare only for enrolled dual eligibles. SNPs were written into statute as MA plans, and are required to structure services, payments, and contracts accordingly. Beginning in 2010, SNPs interested in new or expanded service areas will be required to contract directly with state Medicaid agencies for this purpose.</p> <p>State Examples: Massachusetts, Minnesota, New Mexico, Texas, Wisconsin</p>
Medicaid	<p>Section 1932(a): 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. Although states are prohibited to mandatorily enroll 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.</p> <p>Section 1937: Section 1937 of the Social Security Act provides state Medicaid agencies with the authority to waive statewideness and comparability for certain types of coverage arrangements by permitting states to provide “benchmark” or “benchmark-equivalent” benefits to one or more state populations representing current enrollee classes. Like Section 1932, Section 1937 is not a waiver authority, but rather provides state plan authority to file an amendment to the state Medicaid plan.</p>
Other	<p>PACE: The Program for All-Inclusive Care for the Elderly (PACE) is the first and only federally qualified benefit that fully integrates all Medicare and Medicaid services for the frail elderly eligible for both Medicare and Medicaid. Created by the BBA in 1997, the program 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. Despite evidence that PACE reduces costs for enrollees, growth has been slower than expected. By 2008, only 61 PACE programs were operating in 29 states and while millions of dual eligible adults are potentially eligible, only 17,000 are enrolled.</p>
Waiver Authority	
Medicare	<p>402/222: 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.</p> <p>State Examples: Massachusetts, Minnesota, and Wisconsin began their integrated programs using 402/222 waiver authority before moving to SNP authority.</p>

Waiver Authority (continued)

Medicaid

1115: 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. 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). 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.

State Examples: New York, Wisconsin

1915 (a): 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 Medicaid beneficiaries from obtaining medical assistance from any institution, agency, community pharmacy, or person qualified to perform the services by enrolling Medicaid-eligible beneficiaries in primary care case management or Medicaid managed care. Section 1915(a) does not require an actual waiver or change to the state plan.

State Example: Minnesota

1915 (b): This waiver allows for, among other things, two-year renewable waivers for mandatory enrollment in managed care. 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 Medicaid managed care.

1915 (c): Section 1915(c) of the Social Security Act provides authority for Home- and Community-Based Services Waivers. 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. 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 populations. By doing this, states can provide long-term care services in a managed care environment or use a limited pool of providers.

State Examples (1915 b/c combos): New Mexico, Texas