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After the Deficit Reduction Act: Using Medicaid to Design Accountable Systems of Care for People with Complex and Special Needs

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This issue brief outlines how states can apply the flexibility of the Deficit Reduction Act to develop specialized care models for adults with complex and special health care needs.

Since its inception, Medicaid has focused on meeting the health care needs of people with serious functional limitations and disabilities. The first significant demonstration of Medicaid's potential to foster community-based care came with San Francisco's On Lok demonstration, launched in the 1970s and aimed at averting the unnecessary institutionalization of elderly persons. Over the ensuing decades, Medicaid's transformation to a principal source of support for community living has grown. It is not surprising, then, that policymakers have come to view Medicaid as the nation's single most important public funding tool for furnishing health care and personal health supports to individuals with serious and chronic physical and mental conditions. One of the most important challenges facing state Medicaid programs today is how to avert the health deterioration that can lead to the loss of community residence and considerable, and often avoidable, costs.

Medicaid, however, is a complex program and using it to build and enhance models of care that focus on the individual needs of adults with complex chronic conditions has been challenging. This is in large part due to the fact that the Medicaid program, as is true with health insurance generally, was designed so that all Medicaid enrollees are covered for the same services, regardless of whether they happen to use them in any given year. What makes Medicaid different, however, is that unlike members of employer-sponsored plans, the Medicaid population is not a homogeneous one. Instead it consists of numerous populations including children, adults, and the aged, blind, and disabled (ABD). The ABD population itself is quite diverse and includes not only elderly persons but also persons with physical disabilities and those with developmental disabilities, many of whom may also be dually-eligible for Medicare and Medicaid and all of whom may require a range of medical and supportive/social services from multiple providers and in a variety of settings.[1] Figure 1 shows examples of the various subgroups within the ABD population.

Until recently, states have had to rely on waivers and demonstration programs to develop Medicaid programs that focus specifically on enriching coverage for these population subgroups. However, the Deficit Reduction Act (DRA), passed in 2005, gives states new flexibility over both benefit design and the development and provision of home- and community-based services. This flexibility, combined with existing state flexibility over financial eligibility rules and the use of managed care, may provide new opportunities for developing accountable, integrated service models that focus on adults with disabilities and chronic conditions.

[1] M. Bella, C. Williams, L. Palmer, S.A. Somers, "Seeking Higher Value in Medicaid: A National Scan of State Purchasers." Center for Health Care Strategies, Inc. November 2006.

Figure 1. Examples of the ABD Population

Dual Eligibles. Approximately 7 million persons are enrolled in both Medicare and Medicaid. Dual eligibles are significantly more likely than other Medicare beneficiaries to have serious and chronic health conditions or to be disabled.[2] For this reason, dual enrollees account for a large proportion of total Medicaid spending in relation to their enrollment; in FY 2003, dual enrollees represented 13 percent of total Medicaid enrollment but accounted for 41 percent of total Medicaid spending.[3]

Adults with Disabilities. In 2002, approximately 8.3 million persons received Medicaid on the basis of disability, and nearly four in five persons with disabilities who were enrolled in Medicaid received their Medicaid coverage on the basis of their receipt of Supplemental Security Income (SSI) benefits.[4] Nearly half of all adult Medicaid beneficiaries with disabilities report that they are limited in at least one major life activity as a result of their disability. Virtually all adults enrolled in Medicaid on the basis of a disability have family incomes at or below 200 percent of the federal poverty level.

Low Income Adults with Functional Limitations. Not all non-elderly adults with serious and chronic health conditions enter Medicaid on the basis of disability or dual eligible status. Approximately 25 percent of all Medicaid beneficiaries are adults who enter the program through one of the categories covering low income, non-disabled persons (e.g., AFDC-related, low income parent). Indeed, one study suggests that nearly half of all Medicaid-enrolled adults with activity limitations entered the program through a pathway other than disability status.[5] Comprised overwhelmingly of very low income parents of minor children, these adults appear to be at elevated risk for serious and chronic physical and mental health conditions of a type that may be amenable to effective disease management interventions.

The purpose of this issue brief is to help interested states better understand a subset of the provisions contained within the DRA and how these provisions may be used to further develop specialized care models for complex populations. This paper begins by describing the relevant provisions contained within the DRA and continues with a discussion regarding how DRA reforms might be used in combination with other Medicaid provisions to develop new models of care for adults with disabilities and chronic conditions. The paper concludes with examples of how states can put these care models into practice.

The Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 into law. While the DRA is viewed primarily as a vehicle for providing the nation's governors additional flexibility to contain Medicaid costs,[6] the DRA does add two important new flexibility options where coverage for persons with disabilities and serious and chronic illness are concerned. The first option gives states the ability to build population-specific coverage arrangements that are exempt from the law's normally applicable statewideness and comparability of coverage provisions. This option would permit the creation of either stand-alone coverage or coverage furnished in connection with primary coverage (Medicare or employer-based) to create "customized coverage" tailored to the needs of persons with more extensive and long-term health needs. The second option allows states to offer community-based services tied to functional limits rather than imminent institutionalization.

2 Kaiser Family Foundation. *Dual Enrollees: Medicaid's Role in Filling Medicare's Gaps* (Washington, D.C. 2004).

3 K. Tritz. *Integrating Medicare and Medicaid Services Through Managed Care* (CRS, Washington, D.C. 2006).

4 J. Crowley and R. Elias. *Medicaid's Role for People with Disabilities* (Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. 2003).

5 Center for Health Care Strategies. *The Faces of Medicaid* (Princeton, NJ, 2000).

6 J. Ryan. "Medicaid in 2006: A Trip Down the Yellow Brick Road?" National Health Policy Forum Issue Brief. March 29, 2006.

Flexible benefit design. In terms of coverage, §6044 of the Deficit Reduction Act appears to have little in the way of legal precedent. Because the provision is so potentially far-reaching from the point of view of fashioning Medicaid-supported health care systems for persons with disabilities, the key elements are set forth below in their entirety:[7]

> SEC. 1937. (a) State Option of Providing Benchmark Benefits-
> `(1) AUTHORITY-
> `(A) IN GENERAL- Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through enrollment in coverage that provides—
> `(i) benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2) . . . .
> `(B) LIMITATION- The State may only exercise the option under subparagraph (A) for an individual eligible under an eligibility category that had been established under the State plan on or before the date of the enactment of this section.
> `(C) OPTION OF WRAP-AROUND BENEFITS- In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.
> `(D) TREATMENT AS MEDICAL ASSISTANCE- Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

Although the Centers for Medicare and Medicaid Services (CMS) has not yet issued detailed regulations, the breadth of the text of this provision is potentially enormous, permitting exceptionally wide latitude for states that elect to use this flexibility authority, subject only to the provisions of §1937 itself. The provision appears to set aside all "provisions of this title" for any state that elects to adopt a "benchmark" approach to medical assistance. Since one of the stated purposes of the amendment was to eliminate the statewideness and comparability requirements that traditionally govern Medicaid,[8] the provision appears to allow states to pursue coverage flexibility (either alone or as a wraparound to other forms of coverage) for any eligibility category.[9]

Home- and community-based care options. Flexible benefit design would permit states to extend personal care and other services for specified conditions and diagnoses to individuals whose countable incomes and resources place them within any state plan eligibility category recognized as of the date of enactment. If, however, states desire, they could opt to use new flexibility under DRA §6086 in order to cover certain services as part of a special "home- and community-based care" package, with coverage tied to functional status (an individual's ability to perform activities in the normal course of his/her life to meet basic needs) rather than the need for an institutional level of care that guides current §1915(c) waiver programs.

Figure 2 compares the existing Section 1915(c) option to the new state option to furnish home and community services created by the DRA. Although the new state option uses a lower countable income test (150 percent federal poverty level as opposed to 300 percent), its flexibility is considerably broader with respect to the categorical conditions of eligibility (functional test rather than imminent institutional placement), budget neutrality, and federal oversight. In addition, because budget neutrality is eliminated and the test is a functional test and not an imminent risk test, previous waiver-based barriers to application of the option in the case of persons with serious mental illness would no longer apply.

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7 Emphasis added.

8 SMD 06-008 (March 31, 2006) (flexible benefit arrangement).

9 It is important to note here that states cannot require certain exempt populations (including the elderly and most people with disabilities) to enroll in the new benchmark packages created by the DRA. At the same time, however, CMS may permit default enrollment systems that allow enrollees to opt out, although no formal guidance yet exists on this issue.

Figure 2. A Comparison of Community-Based Service Waivers and DRA Home- and Community-Based Service State Option

Issue	1915(c) Waivers	DRA HCBS Options
Financial and categorical eligibility provisions	Countable income of less than 300% of the federal poverty level Persons must require institutional level of care (hospital, nursing facility or ICF/MR, as determined by state under standards approved by Secretary	Countable income of less than 150% of the federal poverty level Persons must meet a state-developed functional test, which must be less stringent than the level of functional impairment needed for institutional entry. States have the option to modify eligibility standards for HCBS services if enrollment exceeds projections
Scope of the benefit	Case management, homemaker/home health aide services, personal care, adult day health, habilitation, respite care, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness	Same
Geographic, categorical classification, and enrollment limits	States can target specific geographic regions and certain recognized population subgroups	Same, but states can identify the need criteria and populations eligible
Budget neutrality	States can project and limit enrollment; budget neutrality applies to maintain HCBS costs at an average that does not exceed average institutional care costs	Same; no budget neutrality requirements
Treatment planning	Required	Required with specific conditions
Post enrollment/eligibility treatment of income and cost sharing	States may require lower income standards post enrollment/eligibility	States may use cost sharing flexibility post enrollment/eligibility

Medicaid Options for Building Care Models for People with Disabilities and Chronic Conditions

The true potential of the DRA amendments is perhaps best understood against the broader Medicaid program of which they are a part. Traditional Medicaid law has for many years given states the flexibility to: (a) recognize more liberal financial methodologies in determining state plan eligibility for certain populations; (b) utilize targeted benefit strategies via condition-based coverage and practice guidelines; and (c) use both mandatory and voluntary managed care arrangements through comprehensive delivery or primary care case management systems supplemented by specialty arrangements. The DRA amendments, combined with these traditional financial eligibility and coverage options may give greater flexibility to states interested in designing person-centered programs for beneficiaries with disabilities and chronic conditions.

Financial eligibility rules. Medicaid eligibility is determined based on *countable*, not gross, income.[10] Federal Medicaid law that predates the DRA permits states to use more flexible methodologies in setting financial eligibility standards for certain populations, including:

- Persons with disabilities who are able to work;
- Persons who receive state-administered disability supplements;[11] and
- Persons who but for the provision of services described under the home- and community-based services statute, would require institutional care.[12]

These provisions permit states to identify certain eligibility subgroups who are either disabled or who

10 42 U.S.C. §1396a(a)(17)

11 Id.

12 Id.

are at risk for serious and chronic illness or conditions (e.g., parents, persons who meet categorical eligibility standards for SSI or who qualify for institutional care) and adopt more generous financial methodologies to determine eligibility. Because the DRA's benefit flexibility option is limited to "individuals eligible under an eligibility category" established under the state plan at the time of enactment, the only restriction appears to be extending alternative benefits to additional eligibility categories, not the methodologies used to determine individual eligibility under an established category. Thus, the text of the statute does not appear to bar the use of more liberal methodologies for eligibility categories in effect as of the date of enactment.[13] In other words, there is nothing in the DRA that would prevent a state from increasing the level of permissible shelter costs for persons within established categories whose functional impairments are associated with additional monthly expenditures for food, shelter, or community services, for example, in order to get the person down to the 150 percent FPL required by the new state option for HCBS. This approach combines the alternative benefit option with pre-existing flexibility to recognize additional exemptions and disregards in determining eligibility under a state plan eligibility category.

It is worth reiterating here that nothing in the DRA text signals a change in the fundamental concept of countable income or state flexibility over the decision as to what will count as income and resources. Indeed, if anything, the "notwithstanding" language of the DRA's flexible benefit text indicates that unless otherwise limited by the terms of the flexible benefit amendment text itself, Congress anticipated that states would be free to utilize their authority to augment systems of care for persons for whom Medicaid remains a uniquely important source of health care financing. This interpretation of maximum flexibility to aid persons with special needs also is evident in the Secretary's "Roadmap" letter of March 31, 2006[14] and in the efforts to build partnerships between Medicare Advantage and Medicaid supplementation.[15]

Benefits and coverage design. Traditional Medicaid statutory and regulatory standards that require states to adopt utilization review criteria and assure the efficient use of resources permit a wide array of utilization management techniques tied to medical necessity.[16] Practice guidelines and disease management offer two approaches to appropriate utilization management, and CMS has clarified the use of such techniques in primary care case management (PCCM) programs, comprehensive managed care contracts, or on a fee-for-service basis.[17] A well-developed disease management program for conditions such as hypertension, diabetes, depression, sickle cell disease,[18] or other serious and chronic conditions could satisfy both comparability and statewideness requirements (to the extent that such requirements apply) as long as the benefits that are managed are made available without regard to geographic location or specific coverage category (e.g., diabetes management as a covered benefit for both AFDC-related or disabled persons). Alternatively, disease management is an option in managed care contracts administered pursuant to waivers or state plan options.[19] The flexible benefit created through the DRA can cover any mandatory or optional service as long as it either equates to one of the statutory benchmarks (e.g., federal or state employee benefits or the state's most popular HMO) or, if fashioned by the state, meets actuarial equivalency standards and addresses a minimum set of benefit classes (inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, and well-baby and well-child care, including age-appropriate immunizations).[20] States therefore can design a flexible benefit that covers most or all

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13 The legislation was signed into law on February 8, 2006.

14 http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS061265&intNumPerPage=10

15 http://www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp

16 42 U.S.C. §§1396a(a)(17) and (30)

17 SMD 04-002 (Feb. 25, 2004) (disease management; sickle cell coverage as service option).

18 See SMD 05-003 (September 29, 2006) regarding optional coverage of services related to sickle cell disease as a result of the American Jobs Creation Act of 2004.

19 At their option, states can administer managed care pursuant to §1915(b) waiver authority or §1932 of the Social Security Act, which since 1997 has permitted states to pursue Medicaid managed care as a state option. A state might retain its §1915(b) waiver program rather than move to managed care as a state option if one or more aspects of its program might not otherwise satisfy §1932 (for example, inclusion of populations whose enrollment cannot be mandated under §1932).

20 Prescription drugs, mental health, vision and hearing services are an option under flexible benefits.

Medicaid services as well as services not otherwise available under the state plan to general population groups. The flexible benefit can be targeted by population group or by geographic region. The amendment also specifically permits the flexible benefit to supplement employer-sponsored coverage for which the state pays the premium.

Managed care contracting. Finally, states can require mandatory enrollment into managed care for most eligibility groups, either as a state plan option or through the use of waivers. States can use comprehensive managed care organizations (MCOs), entities that furnish more limited services (managed care entities), PCCM arrangements, or a combination of arrangements (e.g., PCCM enrollment with links to one or more specialty service systems operating as a form of a managed care). CMS also appears to permit automatic enrollment with post-enrollment opt-out rights for exempt populations.[21] As a result, states have numerous service delivery options with which to implement programs aimed at providing specialized care for persons with disabilities and chronic conditions.

Applying Medicaid Flexibility Tools to Create Accountable, Person-Centered Care Models for Adults with Disabilities and Serious and Chronic Conditions

There are numerous approaches to translating the flexibility tools outlined above into operational arrangements for persons with disabilities and serious and chronic health conditions. The tools can be used alone or in various combinations, providing states with numerous options for developing customized programs based on the targeted population and overall program goals. The DRA benefit flexibility provision complemented by more liberal financial eligibility methodologies (as allowed under traditional financial eligibility rules) may offer the most promising approach to developing specialized service benefit packages. The concurrent use of these tools may allow states to develop programs that incorporate the full range of services and procedures required by persons with disabilities and complex health care needs, ranging from primary, preventive, and acute, to home- and community-based services. States have at least two additional tools through which they may further enhance their ability to support the varied needs of a diverse population. The first is by adopting the state plan option for home- and community-based care using a functional test geared to a particular target population. The second is by offering the flexible benefit as part of primary coverage or supplemental, wraparound coverage in situations in which other coverage options (such as employee benefits or Medicare Advantage) are also available. Figure 3 illustrates how states can combine the various Medicaid flexibility tools to create programs aimed at providing a targeted population with the most appropriate care in the most appropriate setting.

[21] SMD 06-008 (March 31, 2006) (flexible benefit arrangements).

Figure 3. Using Medicaid Flexibility Tools to Develop Programs for Adults with Disabilities and Serious Chronic Conditions*

Target Population	Program Aim	Medicaid Flexibility Tools			
		DRA Options		Traditional Options	
		Benefit Flexibility	HCBS State Plan Option	Liberal Financial Eligibility Methodologies	Managed Care Contracting
Adults with Disabilities	Provide beneficiaries with additional preventive and supportive services not usually found in traditional Medicaid programs.	✔	✔	✔	
Low Income Adults with Functional Limitations	Provide beneficiaries with chronic care management services not usually found in traditional Medicaid programs.	✔		✔	
Nursing Home Certifiable Medicaid Beneficiaries	Provide beneficiaries with the services needed to keep them in the community.	✔	✔	✔	
Dual Eligibles	Integrate Medicare and Medicaid coverage through state contract with Medicare Advantage Special Needs Plan(s).	✔		✔	✔
ABD Beneficiaries with Access to Employer-Sponsored Insurance	Incentivize work among persons with disabilities through retention and improvement in health benefits.	✔	✔	✔	

*In Figure 3, checked boxes indicate tools that should be used in combination with one another in order to achieve programmatic goals as set forth in the Program Aim; unchecked boxes indicate tools that can be used at a state's discretion based on internal needs, preferences, and priorities.

Conclusion

Medicaid beneficiaries with disabilities and chronic conditions represent Medicaid's most complex and costly population; they account for only one-quarter of the 55 million people served by Medicaid, yet nearly 70 percent of the program spending.[22] This is not surprising of course, given the fact that health care needs are spread unevenly over the population. Yet these statistics also underscore the importance for quality and access reasons of focusing on program investments that are cost effective and that help further states' broad objective of fully integrating persons with disabilities into society. The DRA gives states additional tools for translating innovations that have been known for decades into solid program improvements.

The DRA is primarily thought of as a means for reducing Medicaid outlays. Indeed, this is a primary purpose of the legislation. But some of the options, when used in combination with existing state flexibility, may in fact permit states to strengthen coverage and services for targeted groups of enrollees without either having to get special permission to proceed or make program alterations that implicate costs for the broader Medicaid population.[23] Given CMS' high level of interest in advancing community-based systems of care and promoting the new options under the DRA, it appears that states have broad new opportunities to put these tools to work. The DRA flexible benefit and home- and community-based service provisions, used in combination with traditional financial eligibility and coverage options, provides important new opportunities to better manage the individual needs of this diverse population and reap long-term value in the process.

[22] Kaiser Family Foundation. Medicaid Program at a Glance (Washington, D.C. 2006).

[23] *Medicaid in 2006: A Trip Down the Yellow Brick Road?*, op. cit.

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit organization dedicated to improving the quality and cost effectiveness of publicly financed care for people with chronic health needs, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, providers, and consumers to design programs that better serve high-need and high-cost populations. To achieve its goals, CHCS focuses on three priorities: regional quality improvement, racial and ethnic disparities, and people with complex and special needs.

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