IMPLEMENTING HEALTH REFORM

The Community First Choice Option

The Community First Choice Option is among the lesser-known provisions of the Affordable Care Act. Formally known as Section 2401, this program offers states additional Medicaid funding to provide home- and community-based attendant services and other support to low-income disabled Americans, keeping them in the community and out of nursing homes.

Under the program, states can get a 6 percentage point increase in federal Medicaid matching payments to cover costs associated with providing community-based services such as assistance with activities of daily living and instrumental activities of daily living, as well as health-related tasks. States also would have the option of paying for transition costs, such as the first month's rent when a person moves from a nursing facility back to the community.

Eligibility and requirements associated with the program were outlined in a proposed rule in February; the program is scheduled to begin in October.

Kate Wilber, Ph.D., an expert on gerontology issues from the University of Southern California, explained how the program could help keep more disabled people in the community.

Clinical Endocrinology News: Who will be eligible for assistance under the Community First Choice Option?

Dr. Wilber: Potential participants must live in a state that offers the program, qualify to receive medical assistance under their state's Medicaid program, and have an income below 150% of the federal poverty line. Individuals with higher incomes may participate if they are eligible for a nursing facility level of care that would be covered by the state Medicaid program. Right now, it is unclear how many states will choose to offer the program.

States may have concerns about offering a new entitlement in the current economic climate.

DR. WILBER

CEN: About 35 states already provide some type of personal care services through Medicaid. Is the increased federal payment likely to expand this much?

Dr. Wilber: Close to half of the states have expressed interest in the program. The use of the increased federal match as an incentive is attractive. However, in contrast to waiver services with limited slots, this program is an entitlement, meaning it must be offered to everyone who is eligible. States that have concerns about offering a new entitlement in the current economic climate might take a "wait and see" attitude.

CEN: What impact will this have on nursing home care?

Dr. Wilber: The resident mix in nursing homes has changed dramatically over the last decade or so, driven by factors that support expanded community options. In the 1999 Olmstead decision, the U.S. Supreme Court ruled that institutionalizing individuals who prefer to live in a community setting is discrimination, and that services should be provided in the most integrated and least restrictive setting. Over the last decade, the Centers for Medicare and Medicaid Services (CMS) have sought to reduce the Medicaid bias toward institutionalization by "rebalancing" funding toward more home and community-based service options. One initiative, known as "money follows the person," offers state incentives to transition long-stay residents out of facilities and into the community. States have also taken advantage of Medicaid waiver programs that permit individuals who are eligible for a nursing home level of care to use community-based services instead. The federal government has also funded demonstration programs to test the effectiveness of programs that offer consumer direction by providing cash benefits to purchase services. The Community First Option draws on and expands these options.

CEN: How can primary care physicians direct their disabled patients toward these programs?

Dr. Wilber: Many primary care physicians are not familiar with long-term care services and supports, and the pathway from providing primary care to these services is not easy to find. Some physicians working in larger systems will have access to social workers who can assist patients with complex conditions. Physicians are probably most familiar and most comfortable with skilled nursing facilities and home health care. Beyond that, there are a variety of programs with complex eligibility requirements, various levels of quality, and different funding sources. This is the system that the Institute of Medicine described as "a nightmare to navigate." Although the ACA attempts to address fragmentation, programs such as Community First will be shaped at the state level. Different states will have different approaches, with some choosing not to pursue the program at all. We will know more about what these programs will look like as states begin to develop their approaches.

CEN: The program requires a "person-centered planning process" and gives individuals the authority to hire, fire, and train their attendants. How does that improve the care provided?

Dr. Wilber: Long-term care services and supports are "high touch," highly intrusive personal services that deal with many facets of a person's life over a long period of time. For those receiving these services, it helps to have control over who provides them. Self-direction means care receivers have the authority to tailor their services according to their preferences, needs, cultural expectations, habits, and other life-style requirements. Evidence from self-directed care, such as the "Cash and Counseling" demonstrations have found that these services have good outcomes for the care recipient and caregivers, and are cost effective as well. ■

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Enrollment Lags for Pre-Existing Condition Insurance Plan

BY ALICIA AULT

A federal program to help people with pre-existing conditions obtain health insurance has lagged in terms of the government's projected enrollment, which may be partly because it has largely gone unnoticed as one of the benefits of the health reform law.

The Pre-Existing Condition Insurance Plan (PCIP) was launched in July 2010 with $5 billion in funding from the Affordable Care Act. The goal is to provide an insurance option to people who may be barred from coverage or who have to pay huge surcharges because of a pre-existing condition such as hypercholesterolemia or cancer. The program will be in force until 2014, when the new insurance exchanges go into effect and insurers are prohibited from denying coverage to adults with pre-existing conditions. (They are already barred from doing so for children.)

Although the Department of Health and Human Services initially estimated that several hundred thousand people might benefit from the PCIP, as of early May only about 18,000 people had enrolled, according to the government's statistics.

In an interview, Richard Popper, director of insurance programs at the federal Center for Consumer Information and Insurance Oversight, would not comment on the number of enrollees. He did say, however, that enrollment had been strongest in states with higher populations, such as Texas, California, Pennsylvania, and Illinois.

A "significant number" of patients with cancer, coronary artery disease, chronic obstructive pulmonary disease, and digestive system problems have accessed the program, said Mr. Popper, whose office is a division within the Centers for Medicare and Medicaid Services. The average person who has enrolled has annual medical costs of $20,000 a year, he said.

To be eligible for the PCIP, an individual must have been without insurance for 6 months before enrollment. Mr. Popper said that because he was not working for DHHS at the time the Affordable Care Act was developed, he can't comment on why this waiting period was made an essential part of the eligibility.

After that, the program varies according to whether it is administered by a state or the federal government, although there are minimum coverage criteria. Twenty-three states and the District of Columbia elected to have their PCIP program be federally run, which is essentially the same as the plan offered by Blue Cross/Blue Shield to federal employees.

Twenty-seven states run their own programs.

Patients can apply at the federal government's website (www.pcip.gov). They must prove that they have been denied insurance and have a pre-existing condition. That can be accomplished through a letter of denial from an insurer. In some states, an individual can qualify with a letter from a physician noting the pre-existing conditions and stating that the person has been diagnosed or treated for the conditions within the previous 6 months, said Mr. Popper.

In all cases, the patient gets coverage immediately. There is no waiting period, and premiums will be the same as for a healthy person in the same age range. There are no surcharges for health conditions.

At a meeting of the Association of Community Cancer Centers in March, Mr. Popper cited figures for the plan in Texas, which has a program operated by the federal government. For standard coverage, individuals can expect to pay $174 to $557 monthly, depending on age, with a $2,000 deductible for medical care and a $500 deductible for medications. Higher benefit plans run $234-$749 for premiums, with $1,000 and $250 deductibles, respectively. There is also a health savings account option, with premiums of $181-$578 and a $2,500 deductible.

The out-of-pocket maximum that patients would pay under all plans is $5,950. There is no lifetime limit and no limit on physician visits or prescription drugs.

DHHS is trying to get the word out about the PCIP. When people apply for disability under the Social Security program, they receive notification about the PCIP. Many insurance companies have also been advising patients who are rejected for coverage that the PCIP is a potential alternative, said Mr. Popper. ■