IMPLEMENTING HEALTH REFORM

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 transitions 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., a gerontology expert at the University of Southern California, Los Angeles, explained how the program could help keep more disabled people in the community.

RHEUMATOLOGY 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.

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

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DR. WILBER

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" approach.

RN: 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 several different 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 sought to reduce the Medicaid bias toward institutionalization by "rebalancing" funding toward more home and community-based service options. One initiative to promote rebalancing, 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.

RN: 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 with broader care planning for 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.

RN: 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, often for many hours a day 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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struggling to cover their costs as reimbursement steadily declined from around $148 per scan in 2006 to about $54 in 2010. Exacerbating the problem is that private insurers have largely followed Medicare's lead, ratcheting down their reimbursements as well. The ACA brought DXA payments up to about $98.

Physicians' organizations, including the American College of Rheumatology (ACR) and the American Association of Clinical Endocrinologists, are urging lawmakers to pass an extension of the current DXA payment rate.

Dr. Timothy J. Laing, government affairs committee chair for the ACR and a rheumatologist at the University of Michigan, Ann Arbor, said that if the reimbursement for the test falls below current levels, it will become economically unsustainable for physicians to provide the test in their offices.

Patients still will be able to get a DXA scan in the hospital, but there are downsides to that limited access, Dr. Laing said.

Patients are far more likely to get the test if it can be done at the time it is recommended, he said, adding that providing DXA scans in the office also provides an opportunity for on-the-spot, in-depth counseling from a physician who is knowledgeable about both interpreting the test and treating osteoporosis.

Getting the legislation passed this year will be an uphill battle. "Right now, Congress is deadlocked over the budget, so any bill that is introduced that adds costs to anything is going to be difficult," Dr. Laing said. ■

CMS Aims to Ease E-Prescribing Rules

BY ALICIA AULT

The Centers for Medicare and Medicaid Services has proposed modifying e-prescribing rules so more physicians could claim exemptions from the criteria and therefore avoid being penalized in 2012.

In a conference call, agency officials said the change was in response to indications from providers and professional societies that many prescribers might not be able to meet the requirements of the current incentive program.

"Today's rule demonstrates that CMS is willing to work cooperatively with the medical professional community to encourage participation in electronic prescribing," Dr. Patrick Conway, chief medical officer at CMS and director of the agency's Office of Clinical Standards and Quality, said in a statement.

"These proposed changes will continue to encourage adoption of electronic prescribing while acknowledging circumstances that may keep health professionals from realizing the full potential of these systems right away," he said.

Under the current incentive program, eligible prescribers were due to get a 1% bonus payment for 2011 and 2012 and a 0.5% bonus in 2013. For prescribers who did not meet the criteria, there would be a penalty imposed in 2012. The penalty would escalate in 2013 and 2014.

The final Medicare Physician Fee Schedule for 2011 contains exceptions, along with two hardship exemptions. Practices are exempt if they are in a rural area without high-speed Internet access or an area without enough available pharmacies for electronic prescribing.

Under the proposed rule, prescribers who use certified EHRs can now claim this as a "qualified" e-prescribing system. The move was designed to more closely align the e-prescribing program with the program that offers incentives for meaningful use of EHRs.

The proposed rule would also create four additional hardship exemption categories. Prescribers would have to show that they have:

- ► Registered to participate in the Medicare or Medicaid EHR incentive program and have adopted certified EHR technology.
- ► An inability to electronically prescribe due to local, state, or federal law (this primarily applies to prescribing of narcotics).
- ► Very limited prescribing activity.
- ► Insufficient opportunities to report the electronic prescribing measure due to limitations on the measure's denominator.

Prescribers also would be granted an extension, until Oct. 1, 2011, to apply for the hardship exemption. ■