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CMS NEWS

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CMS TAKES STEPS TO IMPROVE COVERAGE AND SUSTAINABILITY OF CARE FOR DUAL-ELIGIBLE BENEFICIARIES

New Policies Announced for Long-Term Care Partnerships, Medicaid Transfer of Assets and Improved Coordination of Care

To encourage people to make better plans for their future long-term care needs, and to protect the stability of the Medicaid program, CMS today announced a set of important steps to keep coverage secure and improve care and coverage options for people with Medicare and Medicaid.

These policies include new incentives for people to buy private long-term care insurance, improved rules governing the transfer of assets to prevent inappropriate use of taxpayer funded programs, and improved coordination of care for those with both Medicare and Medicaid coverage, the so-called “dual eligibles” who are in managed care plans.

“One of the greatest challenges facing our nation is providing high-quality care for older Americans when their health declines,” said Mark McClellan, MD PhD, administrator of CMS. “As the Baby Boom generation approaches Medicare eligibility we need to make sure that benefits are secure and available for those who need them. Today we announced more steps we are taking to provide well-coordinated care to prevent costly complications for beneficiaries with complex medical problems.

“Older Americans will have a new win-win option to meet their long-term care needs,” added Dr. McClellan. “They will have new, private insurance options for long-term care coverage that enables them to get the kind of assistance they prefer while protecting some of their assets should they ever need Medicaid’s help to pay for long-term care expenses. This new partnership will reduce the pressure on Medicaid financing of long-term care,” added Dr. McClellan.

Medicaid rules normally require applicants to have spent their assets (with some exceptions such as a home or burial funds) before they qualify for Medicaid and its long-term care (LTC) benefit. In fact, the new Deficit Reduction Act of 2005 (DRA) tightens existing rules to discourage individuals from transferring their assets to family members or others to hasten their Medicaid eligibility.

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State Medicaid programs may disregard assets that match, dollar for dollar, the amount paid to an applicant by a private long-term care insurance policy when determining if the applicant meets the asset limits for Medicaid eligibility. Changes made by the DRA, and announced today, will allow those same assets to later be deducted from the amount the state must recover from the beneficiary's estate.

"Partnerships between consumers, the private insurance industry and Medicaid will help people better plan for long-term care needs they may have in the future," said Dr. McClellan. "The Partnership program, we believe, will encourage people to accept personal responsibility for their future long-term care needs by purchasing insurance, and will reduce the incentive to transfer or hide assets that can be protected legally," Dr. McClellan said.

States may apply to Medicaid to adopt LTC Partnership programs as long as they require policies sold under the program to meet strict consumer protection conditions set by the National Association of Insurance Commissioners' (NAIC) long-term care model regulations. California, Connecticut, Indiana, Iowa and New York are already operating LTC Partnership programs under the authority of earlier legislation which will continue to operate.

Under the new program, only persons who purchase LTC insurance policies that meet certain requirements will be eligible to protect assets from estate recovery.

CMS also announced steps to assure that Medicaid benefits for dual-eligibles were targeted to those who have no ability to pay.

"Medicaid is truly not equipped to pay the long-term care expenses of every American," said Dr. McClellan. "We must preserve the program for the future and for those who are its intended beneficiaries."

"Medicaid cannot afford to pay for long-term care services for those who truly need it, if it is used to protect inheritances for those with the assets to pay for the care they need," said Dr. McClellan. "We are taking steps to make sure that Medicaid benefits do not go those who are trying to protect inheritances, but only to those without alternative ways to pay. At the same time we will also work with states to make sure that people who did not deliberately shield assets are not penalized."

Under the Deficit Reduction Act, states must review any transfers of assets by an applicant for less than fair market value for the 60 months prior to in most cases, the date that the individual applied for Medicaid and was institutionalize. Prior to DRA, a state was required to review transfers made in the 36 months prior to that date (or up to 60 months for transfers to trusts). In addition, prior to DRA, a person found to have inappropriately transferred assets for purposes of Medicaid qualification were deemed ineligible for a period of time equal to the amount of time that money would have covered nursing home expenses. The time clock on the asset contribution requirements began with the date of the transfer, not the date of eligibility for Medicaid's long-term care benefit. As a result, assets often would not contribute to deferring Medicaid costs. DRA now requires the clock to start on the later of the date of the transfer of assets or the date that the person would otherwise qualify for Medicaid coverage of LTC expenses.

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At the same time, the DRA provides additional protections to individuals who otherwise would be subject to periods of ineligibility, by strengthening the hardship waiver process. States will be required to verify they have a process to notify applicants that hardship waivers are available. States must also have an appeals process in place. States must make hardship waivers available if the period of ineligibility for Medicaid payment of LTC services would endanger the individual's life or health, or would deprive the individual of food, clothing, shelter, or other necessities of life. Inability of a person to pay for needed nursing home care would be a key factor that states would have to take into account in this process.

Copies of the state Medicaid directors' letters outlining the new policies implementing the DRA can be viewed at http://www.cms.hhs.gov/smdl/smd/list.asp

In another initiative to improve coverage for people with Medicare and Medicaid, CMS also announced a set of steps to improve access to coverage in Special Needs Plans (SNPs) that serve "dual eligible" Medicare beneficiaries.

Different, and sometimes conflicting, Medicare and Medicaid rules have created administrative difficulties for SNPs and confusion for beneficiaries. Medicare Advantage plans often offer one set of benefits but the dually eligible enrollee must go to a different Medicaid managed care plan to receive the wrap around benefits offered by Medicaid, but not Medicare.

"Coordination of services between the Medicare and Medicaid programs is essential to proving the best possible care for our beneficiaries," said Dr. McClellan. "As a physician I know how important it is for patients to have continuity of the care they receive from a single "medical home. Today's changes will make that possible and is a tremendous step toward creating a high standard of care."

In response to concerns about coordination, CMS today released a series of three "how to" guides to help plans understand and integrate the two programs. The guides provide clarification of many Medicare and Medicaid rules in the areas of marketing, enrollment and quality of care. The guides also suggest ways states can streamline their processes to help integrate administration of the two programs such as creating a single enrollment form.

Such coordination is especially important for Medicare Advantage Special Needs Plans which provide care to dual eligibles. Plans that serve special needs populations may want to specialize in services for certain subsets of beneficiaries such as just the disabled or just the elderly.

Under current Medicare rules, such "subsetting" of special groups is not allowed, with limited exceptions. To correct this problem, CMS will soon issue a new policy that will allow plans to serve certain segments of the dual eligibles in which states are providing an integrated Medicaid benefit package. Details of the new policy will be issued soon.

To view the how-to guides, visit the CMS Web site at
http://www.cms.hhs.gov/DualEligible/04StateGuidetoIntegratedMedicareandMedicaidModels.asp

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