

## Provisions Affecting Older Adults in Health Care Reform

On Sunday, March 21, in an historic vote, the U.S. House of Representatives passed H.R. 3590, the Patient Protection and Affordable Care Act, clearing it for signature by President Obama. This comprehensive health care reform bill previously was passed by the Senate on December 24, 2009, and contains a number of provisions which affect older adults. The bill will:

*\* NOTE: Medicare Part D (e.g. closure of the Medicare Part D doughnut hole) and Medicare Advantage payment provisions will be modified by the Reconciliation Act of 2010 (H.R. 4872) if passed by the Senate.*

### Medicare

- **Reduce payments to Medicare Advantage (MA) (Part C) plans** to make them equal (on average per beneficiary) to payments through traditional Medicare. Medicare Advantage plans provide Medicare benefits through a private insurance plan rather than through traditional fee-for-service Medicare run by the federal government. On average, MA plans have been receiving \$135 more per beneficiary per month than the traditional fee-for-service Medicare.

Although the bill will cut MA payments, there are no provisions for cuts to mandated benefits (though as a result of the payment reductions MA plans may cut *extra, optional* benefits such as vision and dental).

The provisions for equalizing payments between MA plans and traditional Medicare are based on a recommendation by the non-partisan Medicare Payment Advisory Commission (MedPAC), and supported by advocates for Medicare beneficiaries such as the Center for Medicare Advocacy. One purpose of these provisions is to **extend the life of the Medicare Trust Fund which, without some intervention, was projected to be depleted in 2017**. These provisions will result in approximately \$118 billion in savings.

H.R. 3590 contains provisions for a 2% bonus for plans which offer specified care coordination benefits. In addition to that, plans will be allowed up to an additional 4% bonus if they are high quality according to the Centers for Medicare and Medicaid Services (CMS) star-rating system. \*

- H.R. 3590 contains provisions for an **“Independent Medicare Advisory Board”** which will have authority to make recommendations for Medicare cost-savings. The recommendations will take effect if Congress does not enact an alternative proposal which achieves the same cost savings. The board cannot not make any recommendations which will impact premiums or benefits. Also, the board will not be allowed to make any recommendations for cuts in a year when national health expenditures grow at a higher rate than Medicare costs. The board is required to make recommendations with beneficiary access in mind. A General Accounting

Office (GAO) study on beneficiary access is required in 2014. Congress is required to reexamine the board in 2017 and will have the option to terminate it.

- The Board is required to produce a public report on system-wide (not just Medicare) health care costs, patient access to care, utilization, and quality of care. It is also required to submit to Congress and the President recommendations to slow the growth of national health expenditures, while preserving or enhancing quality of care.
- **H.R. 3590 contains several beneficial Medicare provisions including** the following:
  - Provides a 50% discount on brand-name drugs and biologics filled in the Medicare Part D coverage gap (doughnut hole) for enrollees with incomes below \$85,000/individual and \$170,000/couple; \*
  - Eliminates Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services;
  - Reduces the Medicare Part D coverage gap (doughnut hole) by \$500 in 2010 (2010 only); \*
  - On the negative side, H.R. 3590 will tie Medicare Part D premiums to income, and will move more Part B and Part D beneficiaries into higher-income categories – meaning higher premiums – due to a freeze on thresholds. \*
  - Medicare coverage, with no co-payment or deductible, for an **annual wellness visit and creation of a personalized prevention assessment and plan**. Prevention services include referrals to education and preventive counseling or community-based interventions to address risk factors.

### **Insurance Reforms**

- Six months after enactment, insurance companies can no longer deny children coverage based on a preexisting condition.
- Starting in 2014, insurance companies cannot deny coverage to anyone with preexisting conditions.
- Effective six months after enactment, insurance companies must allow dependents up to age 26 to stay on their parent's insurance plans.

### **Medicaid**

- H.R. 3590 will increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- H.R. 3590 will **modify the spousal impoverishment statute** to mandate that states include the spousal impoverishment protections in their waiver programs, and that the spouses of all HCBS waiver participants, including those who qualify as

medically needy, have the protections available. The provision will sunset after five years.

- H.R. 3590 will **extend the Medicaid Money Follows the Person (MFP) Rebalancing Demonstration program** through September 2016. The MFP program was authorized in the Deficit Reduction Act of 2005 to encourage states to transition Medicaid enrolled individuals from nursing homes to the community. The Medicaid coverage follows the person to the community and pays for the home and community-based services required.

### **Community First Choice Option**

- H.R. 3590 will **establish the Community First Choice Option**, which will create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to individuals with disabilities in accomplishing activities of daily living and health related tasks. States who choose the Community First Choice Option will be eligible for an enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program.
- The Community First Choice Option also will require data collection to help determine how states are currently providing home and community based services, the cost of those services, and whether states are currently offering individuals with disabilities, who otherwise qualify for institutional care under Medicaid the choice to receive home and community based services instead, as required by the U.S. Supreme Court in *Olmstead v. L.C.* (1999).
- The Community First Choice Option will also modify the Money Follows the Person Rebalancing Demonstration to reduce the amount of time required for individuals to qualify for that program to 90 days.

### **Long-Term Care**

- H.R. 3590 includes **Community Living Assistance Services and Supports (CLASS) program** provisions. The provisions will create a **new national long-term care insurance program** through voluntary payroll deductions that will provide a cash benefit to individuals who are unable to perform ADLs for purchase of community living assistance services and supports.
- According to the Congressional Budget Office, the proposal will reduce the deficit by \$57.8 billion over 10 years due to the payment of premiums by enrollees (the voluntary payroll deductions), and including federal and state Medicaid savings of \$4.4 billion.
- The provisions will allow inclusion of information on private long-term care insurance in the **“National Clearinghouse for Long-Term Care Information”**.
- H.R. 3590 will allocate \$10 million/year for five years to **continue the Aging and Disability Resource Center** initiatives.

## Care Coordination

- H.R. 3590 will **create the Independence at Home demonstration program** to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction.
- H.R. 3590 will **create an Innovation Center at the Centers for Medicare and Medicaid Services** to test, evaluate, and expand different Medicare and Medicaid payment structures to foster patient-centered care and care coordination across treatment settings and slow cost growth.
- H.R. 3590 will require the HHS Secretary to **improve coordination of care for dual eligibles through a new office or program** within the Centers for Medicare and Medicaid Services.
- H.R. 3590 **establishes a Medicare shared savings program** that promotes accountability for a patient population and coordinates services under Medicare parts A & B and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. It will allow groups of providers who voluntarily meet certain criteria to work together to manage and coordinate care for Medicare fee-for-service beneficiaries **through Accountable Care Organizations under Medicare**. ACOs that meet quality performance standards are eligible to receive payments for shared savings if costs are a certain percentage below a benchmark.
- H.R. 3590 will **establish a national Medicare pilot program to develop and evaluate paying a bundled payment** for an episode of care that begins three days prior to a hospitalization and lasts until 30 days following discharge.
- H.R. 3590 will **establish a Medicaid demonstration project to evaluate integrated care around a hospitalization** beginning January 1, 2012 and ending December 31, 2016.
- H.R. 3590 will **create a new Medicaid state plan option under which Medicaid enrollees with chronic conditions** (including a mental health condition, substance use disorder, asthma, diabetes, heart disease, or overweight) **could designate a provider, team of health care professionals, or a health team as their health home**.
- H.R. 3590 will establish a **program to provide grants** to or enter into contracts with eligible entities **to establish community-based interdisciplinary, interprofessional teams to support primary care practices**.

## End-of-Life

- No end-of-life provisions are included in H.R. 3590.

## Nursing Home Transparency

- Require nursing homes to disclose their owners, operators, suppliers, financiers and others they do business with so they can be held accountable for the care their residents receive.

- Require nursing homes to take steps internally to reduce criminal and civil violations.
- Establish a Quality Assurance and Performance Improvement Program to improve quality assurance standards.
- Require the government to implement a system to collect and report information about how well nursing homes are staffed, including accurate information about the hours of nursing care residents receive; staff turnover rates; and how much facilities spend on wages and benefits.
- Require cost reports that nursing homes will file with the government to show expenditures by category—nursing, therapy, capital assets, and administrative services.
- Require civil monetary penalties (fines) to be held in escrow pending appeals rather than allowing nursing homes to delay payment indefinitely while they file appeals.
- Implement a pilot program to improve federal government oversight of nursing home chains that have quality of care problems.
- Provide training for workers who care for residents with dementia and to prevent abuse.

### **Elder Justice**

H.R. 3590 contains the **Elder Justice Act (EJA)** that will:

- Establish an Elder Justice Coordinating Council to make recommendations to the Secretary of HHS on the coordination of activities of federal, state, local and private agencies and entities relating to elder abuse, neglect, and exploitation. Recommendations contained in the report are due in 2 years.
- Provide \$400 million in first time dedicated funding for Adult Protective Services (APS). Provide \$100 million for state demonstration grants to test a variety of methods to detect and prevent elder abuse.
- Provide \$26 million for the establishment and support of Elder Abuse, Neglect and Exploitation Forensic Centers to develop forensic expertise and provide services relating to elder abuse, neglect, and exploitation.
- Provide \$ 32.5 million in grants to support the Long-Term Care Ombudsman Program and an additional \$40 million in training programs for national organizations and state long-term care ombudsman programs.
- Authorize \$67.5 million in grants to enhance long-term care staffing through training and recruitment and incentives for individuals seeking or maintaining employment in long-term care, either in a facility or a community based long-term care entity.

### **Criminal Background Checks**

- Extend to all states an existing pilot program that enables states to conduct **national criminal background checks, including fingerprint checks, on individuals who apply for direct patient access jobs in long-term care facilities and with home care agencies that receive funding from Medicare or Medicaid**, thus eliminating the ability of persons with criminal histories to move from state to state to work with vulnerable seniors and persons with disabilities.

- The federal government will provide Federal matching funds to states to conduct these activities. The provision specifies that the checks should be implemented in such a way that does not result in application fees for long-term care workers.
- States will be required to guarantee (directly or through donations from public or private entities) a designated amount of non-Federal contributions to the program. The Federal government will provide a match equal to three times the amount a state guarantees; except that Federal funds will not exceed \$3 million for newly participating states and \$1.5 million for previously participating states.

### **Workforce**

- Authorizes \$10.8 million to Geriatric Education Centers (GECs) to support training in geriatrics, chronic care management, and long-term care for faculty in a broad array of health professions schools, and direct care workers and family caregivers; develops curricula and best practices in geriatrics.
- Expands the Geriatric Academic Career Awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; creates a parallel Geriatrics Career Incentive Award program for Master's level candidates (\$10 mil. over 3 years);
- Establishes federal traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, and gero-psychiatric nursing.
- Provides grants to foster greater interest among health professionals (advanced practice nurses, clinical social workers, pharmacists, students of psychology) to enter the field of geriatrics, long-term care, and chronic care management.
- Requires federally funded GECs to offer 1 of 2 required activities (in addition to health professions training), one of these activities being to provide at least two courses each year, at no charge or nominal cost, to family caregivers who support frail older adults and individuals with disabilities, in collaboration with appropriate community partners.
- Authorizes \$10 million over three years to establish advanced training opportunities, e.g., tuition support for obtaining a nursing degree or specialized training, for direct care workers (certified nurse aides, home health aides and personal/home care aides) who are already employed in long-term care facilities.
- Provides \$5 million per year in mandatory funding for three years to conduct a Medicaid demonstration in up to six states for development of training programs for personal and home care aides.
- Establishes a national panel of long-term care workforce experts to develop the core competencies for these training programs and to make recommendations on how such training could be provided. Requires the Secretary to conduct an evaluation of the demonstration and report recommendations to Congress.

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