

## Health Care Reform Provisions Affecting Older Adults and Persons with Special Needs

### 3/30/10

On March 23, 2010, President Obama signed a comprehensive health care reform bill (H.R. 3590) into law. On March 30, he signed the Reconciliation Act of 2010 (H.R. 4872) which modifies H.R. 3590. Taken together, these two bills comprise the health care reform package. Important provisions for older adults and people with special needs include:

#### Medicare

- Provides a **\$250 rebate to Medicare beneficiaries** who reach the **Part D coverage gap** in 2010 (Effective January 1, 2010).
- **Gradually eliminates the Medicare Part D doughnut hole** by 2020:
  - For brand-name drugs, requires pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013)
  - For generic drugs, provides federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011)
- Provides Medicare coverage, with no co-payment or deductible, of 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.
- Eliminates **Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home- and community-based services**.
- **Restructure payments to Medicare Advantage (MA) plans** by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas.
- Require the Secretary to suspend MA plan enrollment for 3 years if the **medical loss ratio** is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years. (Effective beginning in 2011.)
- Although the provisions cut MA payments as a whole, there are no provisions for cuts to mandated benefits. 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.
- These and other provisions strengthen Medicare and **extend by nine years the life of the Medicare Trust Fund** which was projected to be depleted in 2017.
- Applies the **Medicare tax to net investment income** for individuals making \$200,000 and over and couples making \$250,000 and over.

On the negative side, H.R. 3590:

- Establishes an **Independent Payment Advisory Board (IPAB)**, which will have authority to make recommendations for Medicare cost-savings. The recommendations will take effect if Congress does not enact an alternative proposal that achieves the same cost

savings. The board cannot make any recommendations that will impact premiums or benefits. Also, the Secretary of Health and Human Services shall not implement the Board's 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 Government Accountability Office study on beneficiary access is required in 2014. Congress has the option to reexamine the board in 2017 and will have the option to terminate it. The IPAB 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 also is required to submit to Congress and the President recommendations to slow the growth of national health expenditures, while preserving or enhancing quality of care.

- Ties **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.

### **Insurance Reforms**

- Effective 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**.
- Provides immediate assistance to individuals with pre-existing conditions through **establishment of high-risk pools**.
- Ensures that minimum covered benefits include products and services that enable people with disabilities to maintain and improve function, such as **rehabilitation and habilitation services and devices and mental health services**.
- Effective January 1, 2014, requires insurers to accept any employer and individual that applies for coverage (**guaranteed issue**).
- Effective six months after enactment, require individual and group plans to extend **dependent coverage to adult children up to age 26**, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.
- Require group plans to **eliminate lifetime limits** on coverage and beginning in 2014, **eliminate annual limits** on coverage.
- Requires the Centers for Medicare and Medicaid Services to **collect data on beneficiaries with disabilities**, access to primary care services and the level to which primary care providers have been trained on disability issues.

### **Medicaid**

- **Expands Medicaid** to cover individuals 64 and under with incomes up to 133 percent of the federal poverty line.
- States would be required to **maintain the same Medicaid income eligibility levels** through December 31, 2013 for all adults. This “maintenance of effort” (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, **a State would be exempt from the MOE requirement** for optional, non-pregnant, non-disabled adult populations whose family income is above 133 percent of FPL, if the State certifies to the Secretary of Health and Human Services that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.

- **Increases federal Medicaid matching** to all states (except expansion states) as follows: 100% in 2014, 2015, and 2016; 95% in 2017, 94% in 2018; 93% in 2019 and 90% thereafter to finance coverage for newly eligible individuals.
- Increases the **Medicaid drug rebate percentage for brand name drugs** to 23.1 percent (except the rebate for clotting factors and drugs approved exclusively for pediatric use, which increases to 17.1 percent); increase the Medicaid rebate for non-innovator, multiple source drugs to 13 percent of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Modifies 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.
- Extends 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 communities. The Medicaid coverage follows the person to the community and pays for the home and community-based services required.
- Modifies the Money Follows the Person Rebalancing Demonstration to reduce the amount of time required for individuals to qualify for that program to 90 days.

#### **Community First Choice Option**

- Establishes the **Community First Choice Option**, 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 that 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. This provision sunsets 5 years after it starts on October 1, 2011.
- The Community First Choice Option also will require data collection to help determine how states currently are providing home- and community-based services, the cost of those services, and whether states currently offer 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).

#### **Long-Term Care**

- Establishes the **Community Living Assistance Services and Supports (CLASS) program**, a **new national long-term care insurance program** funded through voluntary payroll deductions, which will provide a cash benefit to individuals who are unable to perform ADLs for the purchase of community living assistance services and supports. According to the Congressional Budget Office, the CLASS program will reduce the deficit by \$70 billion over 10 years due to the payment of premiums by enrollees (the voluntary payroll deductions) in excess of benefits paid out in the first decade, and including federal Medicaid savings.
- Creates the **State Balancing Incentive Program** (10/1/2011 – 9/30/2015) to provide enhanced federal Medicaid matching to states which currently spend less than 50 percent of

total expenditures for long-term care on services in the home or community to increase their proportion of non-institutionally-based long-term care services.

### **Care Coordination**

- Creates the **Independence at Home demonstration program** to provide high-need Medicare beneficiaries with primary care services in their homes 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.
- Creates 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.
- Requires the Secretary of Health and Human Services to **improve coordination of care for dual-eligibles** through a new office or program within the Centers for Medicare and Medicaid Services.
- Establishes a **Medicare Shared Savings Program** that promotes accountability for a patient population and coordinates services under Medicare parts A and B, and will encourage 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 (ACOs) 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.
- Establishes 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.
- Establishes a **Medicaid demonstration project** beginning January 1, 2012, and ending December 31, 2016 to evaluate **integrated care around a hospitalization**.
- Creates 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 weight problem) can designate a provider, team of health care professionals, or a health team as their **health home**.
- 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**

- Requires **nursing homes to disclose their owners**, operators, suppliers, financiers, and others with whom they do business so they can be held accountable for the care their residents receive.
- Requires nursing homes to take steps internally to **reduce criminal and civil violations**;
- Establishes a **Quality Assurance and Performance Improvement Program** to improve quality assurance standards.

- Requires 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.
- Requires **cost reports** that nursing homes will file with the government to show expenditures by category — nursing, therapy, capital assets, and administrative services.
- Requires **civil monetary penalties (fines) to be held in escrow** pending appeals rather than allowing nursing homes to delay payment indefinitely while they file appeals.
- Implements a pilot program to improve federal government **oversight of nursing home chains** that have quality of care problems.
- Provides **training to workers** who care for residents with dementia and to prevent abuse.

### **Elder Justice**

H.R. 3590 contains the **Elder Justice Act (EJA)**, which:

- Establishes an **Elder Justice Coordinating Council** to make recommendations to the Secretary of Health and Human Services on the coordination of activities of federal, state, local and private agencies and entities relating to elder abuse, neglect, and exploitation. Recommendations are due in two years.
- Provides \$400 million in first time dedicated **funding for Adult Protective Services (APS)**.
- Provides \$100 million for state **demonstration grants** to test a variety of methods to detect and prevent elder abuse.
- Provides \$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.
- Provides \$ 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.
- Authorizes \$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**

- Extends 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.
- 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; GECs also will develop curricula and best practices in geriatrics.
- Expands the **Geriatric Academic Career Awards** to advanced practice nurses, clinical social workers, pharmacists, and psychologists, and create a parallel Geriatrics Career Incentive Award program for Master's level candidates (\$10 million over 3 years).
- Establishes **federal traineeships** for individuals who are preparing for advanced education 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, and students of psychology) to enter the field of geriatrics, long-term care, and chronic care management.
- Requires federally funded GECs to offer one of two required activities (in addition to health professions training), one being to **provide at least two courses each year**, at no charge or nominal cost and in collaboration with appropriate community partners, **to family caregivers** who support frail older adults and individuals with disabilities.
- Authorizes \$10 million over three years to establish **advanced training opportunities** — such as 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 already are employed in long-term care facilities.
- Provides \$5 million per year, 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. This requires the Secretary of Health and Human Services to conduct an evaluation of the demonstration and report recommendations to Congress.

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