Testimony for Lisa R. Shugarman, Ph.D.

Director of Policy, The SCAN Foundation

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Much of the focus of the new health care reform law involves improving health care coverage for the uninsured and underinsured. In addition to this critical goal, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) also lays the groundwork for wide-ranging continuum of care reform by establishing a framework for care coordination and integrated services across providers and settings. Currently, the continuum of care, composed of primary, acute, and rehabilitative medical services along with supportive long-term care services, is fragmented and unsustainable. The ACA presents many opportunities to improve long-term care, concurrently creating and strengthening linkages between medical care and supportive services. The Little Hoover Commission requested answers to three key questions in relation to the ACA and long-term care, and I respond to these inquiries in my written testimony below.

What are the long-term care provisions in the reform package?

Given the current absence of comprehensive long-term care financing, low consumer uptake of private long-term care insurance, and low savings rates among those nearing retirement, many middle-class aging boomers will likely have substantial difficulty paying for future long-term care needs. The few middle class protections that exist currently are only available for those in nursing homes and not for those receiving services in the community, where individuals overwhelmingly prefer to live as they age.

The ACA presents a new era of long-term care reform beginning with the Community Living Assistance Services and Supports (CLASS) program. CLASS will, for the first time, provide the middle class with the opportunity to access supportive services in the setting of their choice without impoverishing themselves to Medicaid eligibility. CLASS fundamentally reframes the concept of long-term care from one of poverty, sickness, and loneliness to one of choice, community, and personal responsibility in the face of functional impairment.

The CLASS program represents the beginning of a public long-term care safety net based on a risk pool concept. CLASS is a voluntary, federally-administered insurance program for employed individuals with no exclusion for pre-existing conditions and offers a lifetime benefit for people with significant difficulty performing daily living tasks. Premiums will be age-rated, with younger people paying less and older adults more. A vesting period requires enrollees to pay premiums for at least five years prior to receiving benefits. Benefits would be cash payments averaging $50 dollars a day for those certified to have substantial functional impairment and could be used to purchase a variety of supports and services, including home care, adult day programs, assisted living, or institutional care. Daily support provided by CLASS

will offer a stable source of funding, potentially leading to the availability of more reliable home- and community-based services (HCBS) that strengthen the continuum of care.

Medicaid Home and Community-Based Services Provisions in the ACA

In addition to CLASS, the ACA contains several provisions allowing states to expand access to Medicaid HCBS, while also providing financial incentives through increased Medicaid federal matching rates.

- *Community First Choice:* The ACA establishes a new Medicaid State Plan option that provides community-based attendant services and supports to beneficiaries meeting the state's criteria for nursing facility eligibility. States that choose this option will receive a six percentage point increase in their Federal Medicaid Assistance Payments (FMAP – the federal government's share of the Medicaid program) for eligible services. Eligibility is limited to individuals with income levels at or below 150% of FPL, as well as individuals deemed eligible for an institutional level of care under the Medicaid State Plan. Not only will the Community First Choice option cover the costs of personal attendant services and supports, but it allows states to use funds to cover the costs of community transition supports (e.g., rent/utility deposits, first month's rent and utilities, bedding, basic kitchen supplies) for eligible individuals who wish to return to the community. Through this provision, these and other covered services must be provided statewide and must be based on individual need rather than categorical eligibility criteria (e.g., age, disability, etc.). This option will be effective October 1, 2011.
- *Medicaid Home and Community-Based Services State Plan Option:* The Deficit Reduction Act (DRA) of 2005 allowed states to amend Medicaid State Plans to include HCBS as an optional benefit (authorized as section 1915(i)). Since its inception, few states have opted for the 1915(i) State Plan option because of several programmatic limitations. The 1915(i) option is similar to the 1915(c) HCBS waiver, but does not require individuals to meet an institutional level of care in order to qualify. In addition, the 1915(c) waiver programs are allowed to enroll individuals with incomes up to 300% of SSI. The 1915(i) State Plan option, as written in the DRA, allowed enrollment of those with incomes up to 150% of the FPL, which is a more stringent income eligibility criterion than 300% of SSI. The 1915(i)'s restrictive eligibility criterion made it a less viable alternative for states interested in expanding access to HCBS. Now under the ACA, the 1915(i) option permits states to both extend HCBS enrollment to individuals with incomes up to 300% of SSI and offer the full range of Medicaid benefits to individuals receiving services through the 1915(i) option. Additionally, the law requires "statewideness" of services, meaning that the 1915(i) option must be made available to all eligible individuals. Revisions to the 1915(i) will be in effect starting October 1, 2010.
- *Money Follows the Person (MFP):* Also established in the Deficit Reduction Act of 2005, the Money Follows the Person demonstration was authorized through 2011 to assist eligible Medicaid beneficiaries residing in health or nursing facilities with transition from institutional settings to the community. The state's FMAP increases for services

provided to eligible individuals within the first year of transition, in order to provide necessary services and supports for a successful transition. The ACA extended the MFP demonstration through September 2016, appropriated an additional $2.25 billion, and shortened the institutional residency requirement from six months to 90 days. For states already participating in MFP, CMS will not require submission of a grant proposal for additional funds. For states that are not currently participating in MFP, a grant solicitation was released in July 2010 and applications are due January 2011.

- *State Balancing Incentive Payments Program:* The ACA offers new financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into HCBS. Eligible states will be those that, in FY2009, spent less than 50% of total long-term care expenditures on HCBS. Qualifying states will receive an enhanced FMAP for the period FY2012-FY2015. States that allocate less than 25% of the total long-term care budget to HCBS will receive a 5 percentage point FMAP increase for related services. States that allocate between 25% to less than 50% of the total long-term care budget to HCBS will receive a 2 percentage point FMAP increase. States may increase the income eligibility standards for Medicaid HCBS. States choosing to participate in this program will be required to establish a "single entry point – no wrong door" system to streamline access to HCBS. This program will be in effect in October 2011 for states that meet the eligibility criteria and choose to apply.

Other Related Provisions

- Currently, states provide *spousal impoverishment protections* that allow spouses of individuals residing in nursing facilities to retain additional income and assets to keep them from becoming impoverished. The ACA extends this protection to spouses of individuals residing in the community and receiving Medicaid-funded HCBS. This provision will be effective on January 1, 2014 for five years.
- *Aging and Disability Resource Centers (ADRCs)* serve as a single point of entry to assist individuals with disabilities and/or chronic conditions in accessing health care, medical care, social supports, and other long-term services and supports. The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) have funded one or more ADRCs in most states. The ACA appropriates additional funds and extends the ADRC program through 2014. The grant solicitation was released on May 31, 2010 and applications were due in July 2010.
- *Care Transitions Programs* are evidence-based service delivery protocols that seek to assist high-risk individuals with a smooth transition back to the community following a hospital or rehabilitative nursing home episode. This provision, initially envisioned to target hospitals with high re-admission rates, is joined with the ADRC grant solicitation described above and will provide funds to states that have previously received an ADRC or Hospital Discharge Planning Grant Award.
- *Support for the Direct Care Workforce:* The ACA establishes two workforce-related governing bodies to examine workforce issues including workforce supply, education

and training, and retention practices. The Personal Care Attendants Workforce Advisory Panel was written into the CLASS Act to advise on issues related to the direct care workforce (nominations for this panel closed on June 18, 2010). The National Health Care Workforce Commission considers a broader array of the workforce but incorporates issues related to the direct care workforce specifically (nominations for this panel closed on June 30, 2010). Two training grant solicitations have also been released by the Health Resources and Services Administration (HRSA) as directed by the ACA. The Personal and Home Care Aide State Training Program will establish demonstration programs in up to six states for the purposes of developing core competencies, pilot training curricula, and to develop certification programs for personal and home care aides (applications were due on July 19, 2010). The Nursing Assistant and Home Health Aide Program establishes a new three-year program for up to 10 community college and/or community-based training programs to provide support for the development, evaluation and demonstration of a competency-based curriculum for nursing assistants and home health aides (applications were due on July 22, 2010). Finally, the ACA established State Health Care Workforce Development Grants that will provide one-year grants to states to develop partnerships to produce a comprehensive health care workforce at the state and local levels. The grants will be a maximum of $150,000, but will require each state grantee to provide a limited level of matching funds (applications were due on July 19, 2010).

Other important components of the ACA are outlined in the companion policy brief produced by The SCAN Foundation. These include accountable care organizations, post-acute bundling pilots, medical/health homes, improvements to Medicare Part D, quality improvements for nursing homes, and the Elder Justice Act.

What new opportunities might be available – under health care reform or by way of modeling innovations made in other states – for California to expand its capacity to provide long-term care services?

California has taken active steps to capitalize on various opportunities provided under the ACA. Below are some examples of California's efforts to strengthen and build upon its long-term care system.

Of the four approaches to expanding Medi-Cal HCBS through the ACA, three are potentially viable options for California: Community First Choice, 1915(i), and Money Follows the Person. California is not a candidate for the State Balancing Incentive Payments option because the most recent data indicate that California invests approximately 52% of its long-term care dollars in HCBS.

The Community First Choice option is a potential opportunity for California to consider when it becomes effective in October 2011. However, further federal guidance is needed regarding eligibility provisions. As currently defined, the eligibility criteria would increase financial eligibility beyond California's current standard, thereby bringing a greater financial burden to the state. In addition, many of the services authorized under Community First Choice are

similar to what California provides under its In Home Supportive Services (IHSS) program. Therefore, it is not clear if this Community First Choice option would be a net benefit to the state.

The 1915i Medicaid HCBS State Plan option (1915(i)) is another alternative for California to consider. Currently, only four states offer the 1915(i) option. Many states have not chosen this option as it establishes an entitlement to HCBS beyond the current standard of nursing home eligibility, thereby making it cost-prohibitive. However, the revisions outlined in the ACA may make this option more appealing. The CMS directive to State Medicaid Directors provides further guidance to states, permitting design of a service package to specific, targeted populations. To that end, the Departments of Health Care Services, Rehabilitation, and Mental Health are in the process of developing a 1915(i) application to extend HCBS to residents with traumatic brain injury (TBI).

In 2007, California was awarded a grant to implement a Money Follows the Person (MFP) Demonstration project, called California Community Transitions. There are additional funds made available through the ACA to encourage states that have not yet applied for MFP to submit an application. Given that California is already a grantee, these funds are not relevant. However, the ACA also extends the MFP program through 2016 and reduces the number of days one must reside in an institution to be eligible for the MFP benefit from 180 days to 90 days. These eligibility changes may increase opportunities for the state to transition more nursing home residents back into the community.

Beyond expanding Medi-Cal HCBS through the provisions described above, California is seeking to maximize opportunities through three additional initiatives: ADRC expansion with Evidence-Based Care Transitions, Direct Care Workforce training, and the 1115 waiver application.

In response to the grant solicitation released by CMS and AoA at the end of May, the California Health and Human Services Agency, the California Department of Health Care Services, and the California Department of Aging have submitted proposals to enhance and expand the role of Aging and Disability Resource Centers (ADRCs) in the state. In total, four proposals were submitted to respond to each of the four components of the solicitation: 1) outreach and education to people likely eligible for benefits; 2) ADRC options counseling and assistance programs; 3) ADRC nursing home transition and diversion programs; and 4) ADRC evidence-based care transition programs. If awarded, the funds will help reinforce the information and assistance infrastructure in the state through a “single entry point” approach, as well as support the concepts of care coordination while expanding opportunities to receive HCBS. It is not known yet if the state will be awarded funds for these proposals.

California is also making strides to support the existing direct care workforce and plan for the workforce needs of the state going forward. Among other grant opportunities, the California Workforce Investment Board (State Board), in partnership with the California Office of Statewide Health Planning and Development (OSHPD), has submitted an application for one of the State Health Care Workforce Development Planning Grants authorized under the ACA. Specifically, the State Board requested $150,000 to establish a Health Workforce Development Council. Through the Council, the State Board will convene public and private health workforce and education stakeholders in order to develop a comprehensive plan for health workforce

development in California. Additionally, the Governor designated the California Community Colleges System as the lead for the state's application under the Personal and Home Care State Training program. Pasadena City College took the lead in drafting the proposal. Finally, OSHPD provided technical assistance for and a letter of support to Solano Community College in support for its application under the Nursing Assistant and Home Health Aide program. The federal government is currently reviewing applications for this funding opportunity.

In addition to the responses to the opportunities in health care reform, the Department of Health Care Services has submitted an application to CMS for an 1115 waiver, which allows states to test out new approaches to organizing health care in the Medicaid program. As of August 15, 2010, California's 1115 waiver renewal application is pending CMS approval. The new waiver application continues the work of the prior waiver by seeking to expand the availability of health care coverage to more California residents through Medi-Cal. In addition, the new waiver seeks to improve care coordination for some of the state's most vulnerable residents, among them seniors and people with disabilities and those who are dually-eligible for Medicare and Medi-Cal. The dual eligible portion of the waiver application seeks to establish four pilot sites to test different approaches to integrating acute and long-term care services.

How can we ensure that California takes advantage of these opportunities?

As noted above, California is pursuing many options both within and outside the health care reform law to reinforce and strengthen the state's long-term care system. But more can be done. Below are The SCAN Foundation's recommendations.

- *Support the CLASS program.* To ensure that CLASS is a healthy and vibrant insurance program operating alongside private long-term care insurance, it is imperative to have broad participation across all walks of life. This calls for a paradigm shift that combines increasing personal responsibility for long-term care needs in partnership with government support, both of which are needed to achieve a sustainable, efficient long-term care system in California. The state has an opportunity to support this national effort by encouraging residents to be more invested in their own futures through public education campaigns to inform residents of the high likelihood of needing long-term care in old age. Employers will also play a key role in educating and informing workers about the need for and opportunities in CLASS as well as assist employees with enrollment. State and local governments are collectively the largest employer in the state and should take the lead in making CLASS available to its employees. In addition, the state can help foster public/private partnerships with large and small employers alike to educate the general public about the availability of the CLASS insurance program.
- *Help the State explore the potential to apply for enhanced Medicaid HCBS options.* Of the four Medicaid HCBS expansion opportunities described previously, there are three that may be viable options for the state. Consistent with the recently disseminated State Medicaid Directors letter from CMS regarding the 1915(i) State Plan option, the opportunities available through the ACA are important tools for California to serve

individuals in the most integrated setting possible, building a strong continuum of care, and meeting the state's obligations under the Americans with Disabilities Act and the *Olmstead* decision.

- *Continue to identify ways to support and grow the direct care workforce.* California has already taken great strides to help support the current and anticipated direct care workforce by submitting proposals to HRSA to access funds available through the ACA. The outcome of these applications is still unknown. Regardless of whether California is awarded any funds through these mechanisms, the state will need to continue to identify ways to support and grow a well-trained direct care workforce. This is critical to ensuring an available and sufficiently trained workforce supply to address the increasing demand for services as the boomer population ages. It is also particularly important for CLASS program implementation, given that states will be required to have an adequate direct care workforce infrastructure as part of this provision.
- *Pave the way to successful care coordination and service integration for vulnerable seniors and people with disabilities.* Encourage the legislature and the next Administration to provide the necessary resources to ensure that the 1115 waiver proposal (if approved) is implemented successfully and in line with recommendations made by a diverse array of stakeholders through a careful and extended work group process throughout last year. The 1115 waiver, at its core, embraces the goal of care coordination whereby individuals and their loved ones are at the center of health and long-term care planning, decision making, and implementation. Efforts to transform the health and supportive service systems toward a care coordination approach for some of California's most vulnerable populations have great potential to impact the wider service delivery systems serving others who are or will become vulnerable due to a chronic health condition or disability and require services in California.

Conclusions

Through the implementation of ACA initiatives to improve access to community-based long-term care services, to encourage uptake of CLASS, to support increased access to ADRCs, and to grow the needed direct care workforce, a new system can be created that is truly greater than the sum of its parts. It is a system that will be better able to absorb the new and likely substantial demand for long-term care services created by a population that will grow exponentially in the next 20 years as a result of the aging of the boomer population. While it is far from perfect, the new health care reform law is an opportunity to transform long-term care and supports a vision that is person-centered, more accessible, affordable to all and offered in the most appropriate and preferred settings.

A Summary of the Patient Protection and Affordable Care Act (P.L. 111-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590, P.L. 111-148), which was passed by the Senate on December 24, 2009 and by the House on March 21, 2010. Following closely on its heels was the Health Care and Education Reconciliation Act of 2010, which makes changes to the Patient Protection and Affordable Care Act. The reconciliation bill was passed by both houses of Congress on March 25, 2010 and signed into law by the President on March 30, 2010. This Policy Brief presents an analysis of the Patient Protection and Affordable Care Act, covering those elements that provide support for the continuum of care for seniors. The Health Care and Education Reconciliation Act of 2010 modified a few provisions in the health reform law specific to the continuum of care, and these modifications are noted where relevant.

The organizing framework for this analysis includes the following concepts about the continuum of care: 1) support the rebalancing of the long-term services and supports (LTSS) available to seniors toward home and community-based services; 2) improve the coordination of health and supportive services, especially for those with chronic illnesses; 3) improve access to medications and reduce the cost burden on seniors; 4) reinforce the existing workforce and establish initiatives to grow the workforce that serves seniors, including direct care workers; and 5) strengthen quality and consumer protections for seniors.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
Dates Introduced & Passed	*Announced: November 18, 2009; Passed by Senate: December 24, 2009; Passed by House: March 21, 2010; Signed into Law: March 23, 2010*	*Introduced March 18, 2010; Passed by House: March 21, 2010; Passed by Senate with Revisions: March 25, 2010; Revised Bill Passed by House: March 25, 2010; Signed into Law: March 30, 2010*
1. Bolstering Supportive Services Delivered at Home and in the Community		
Community Living Assistance Services and Supports (CLASS) plan	Establishes a new public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. • Financed by voluntary payroll deductions or contributions from all eligible adults • Those eligible to enroll are actively employed (including self-employed) adults age 18 and older • Automatic enrollment with an opt-out option; if an employer does not elect to deduct and withhold premiums on behalf of an employee, an alternate payment mechanism will be available for an eligible individual • 5-year vesting period • Enrollees will be eligible for benefits after meeting specified disability criteria (functional and/or cognitive impairment that is expected to last for 90 days or more and is certified by a licensed health care practitioner) • Upon determination of eligibility, a cash benefit will be paid based on functional ability, averaging not less than $50 per day, with no lifetime or aggregate limit • Secretary is required to establish premiums to ensure solvency for 75 years	No changes made.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
	• Medicaid enrollees receiving home and community-based services (HCBS) or Program for All Inclusive Care of the Elderly (PACE) would retain 50 percent of their cash benefit while living in the community • Medicaid enrollees in institutions would retain 5 percent of their cash benefit • Premium subsidies would be available for eligible individuals ages of 18 to 22 who are full-time students while working or for any individual with income below the poverty line • Self-employed individuals could enroll • The CLASS program will be treated in the same manner as a qualified long-term care insurance policy • No taxpayer funds (e.g., Federal funds from any source other than from premiums collected in the CLASS program) will be used to pay benefits under this provision. • The Secretary must establish an eligibility assessment system by January 1, 2012 and designate the benefit plan by October 1, 2012. (Title VIII, Sec. 8002)	
Community First Choice Option	Establishes a Medicaid State Plan Option to provide a community-based attendant services and supports benefit to those who meet the state's nursing facility clinical eligibility standards. • Provides 6 percentage point increase in FMAP to States choosing this option • States would be authorized to provide community transitions support (e.g., rent/utility deposits, first month's rent and utilities, bedding, basic kitchen supplies) to institutionalized individuals who meet the eligibility criteria. • Effective start date was October 1, 2010. (Title II, Subtitle E, Sec. 2401)	The Reconciliation Bill changed the implementation start date to October 1, 2011. (Title I, Subtitle C, Sec. 1205)
Removal of Barriers to Providing Home and Community-Based Services	Amends Section 1915(i) of the Social Security Act to remove barriers to providing HCBS by giving States the option to provide more types of HCBS through a State Plan amendment to individuals with higher levels of need, rather than through waivers. • Requires "State-wideness" of the HCBS State Plan benefit • Prohibits States from setting caps on the number of individuals who receive coverage for the benefit • Enables States to target benefits to individuals with selected conditions if the State wishes • Individuals receiving coverage under the State Plan are grandfathered into services if the criteria for eligibility are modified for as long as their condition meets the previous criteria. • Effective on the first day of the first fiscal year quarter that begins after the date of enactment of this Act. (Title II, Subtitle E, Sec. 2402)	No changes made.
Money Follows the Person Rebalancing Demonstration	Extends the Money Follows the Person Rebalancing Demonstration, originally authorized in the DRA, through September 30, 2016. Modifies eligibility rules, which originally required that individuals reside in facility for not less than 6 months, by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. Amendments effective 30 days after enactment of this Act. (Title II, Subtitle E, Sec. 2403)	No changes made.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014. (Title II, Subtitle E, Sec. 2404)	No changes made.
Funding to Expand State Aging and Disability Resource Centers	Appropriates to the Secretary of HHS $10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives provided in the Older Americans Act. (Title II, Subtitle E, Sec. 2405)	No changes made.
Sense of the Senate Regarding Long-Term Care	Expresses the *Sense of the Senate* that during the 111th Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as in institutions. (Title II, Subtitle E, Sec. 2406)	No changes made.
Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes	Creates the State Balancing Incentive Payments Program with new financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community-based services. • Eligible States are those that spend less than 50 percent of total expenditures for LTSS on services in the home or community • The Secretary may determine among the States that apply and qualify which will participate • Qualifying States with less than 25 percent of total LTSS expenditures for HCBS will receive a 5 percentage point increase in FMAP; States with 25-50 percent will receive a 2 percentage point increase • As part of this provision, States may increase the income eligibility for HCBS • Requires qualifying States to establish a statewide "No wrong door – single entry point system" to enable consumer to access LTSS • Requires qualifying States to develop case management services to assist in the development of a service plan for beneficiaries and for family caregivers; also provide case management to support the transition from institutional to community-based services • Allocates up to $3 billion for Medicaid HCBS. (Title X, Subtitle B, Part I, Sec. 10202)	No changes made.
2. Improving Coordination of Health Care and Supportive Services		
Building Infrastructure for Program and Policy Development		
Medicaid and CHIP Payment and Access Commission (MACPAC)	Clarifies the topics to be reviewed by the Medicaid and CHIP Payment and Access Commission (MACPAC) including: • Medicaid and CHIP enrollment and retention processes, coverage policies, quality of care, how interactions of policies between Medicare and Medicaid affect access to services, payments, and dually-eligible individuals, and additional reports of State specific data • Authorizes $11 million to fund MACPAC for FY2010. (Title II, Subtitle J, Sec. 2801)	No changes made.
Improved Coordination and Protection for Dual Eligibles	Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare and Medicaid Services (CMS) by March 1, 2010. The purpose of the CHCO will be to bring together officials of the Medicare and Medicaid programs to: • More effectively integrate benefits under those programs, and • Improve the coordination between the federal and state governments for individuals eligible for	No changes made.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
	benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled. • The goals of the CHCO are: o Provide dual eligibles full access to benefits to which they are entitled under Medicare and Medicaid; o Simplify the process by which dual eligibles access services; o Improve the quality of health and long-term care services for dual eligibles; o Increase dual eligibles understanding of and satisfaction with coverage; o Eliminate regulatory conflicts between Medicare and Medicaid; o Improve care continuity for dual eligibles; o Eliminate cost shifting between Medicare and Medicaid and among related health care providers; and o Improve the quality of performance of providers under Medicare and Medicaid. • Specific responsibilities include: o Provide States, Special Needs Plans, and providers with education and tools to align Medicare and Medicaid benefits; o Support State efforts to coordinate and align acute and long-term care services for dual eligibles; o Provide support for coordination, contracting and oversight by States and CMS with respect to integrating Medicare and Medicaid; o Consult and coordinate with MedPAC and MACPAC regarding relevant policies; o Study the provision of drug coverage for new full-benefit dual eligibles and monitor and report total annual expenditures, outcomes and access to benefits for dual eligibles; and o Submit an Annual Report to Congress with recommendations for legislation to improve care coordination and benefits for dual eligibles. • Effective March 1, 2010. (Title II, Subtitle H, Sec. 2602)	
Establishment of Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS)	Establishes within CMS a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare as well as payment reform models. Successful models can be expanded nationally. Requires the Secretary to focus on models that both improve quality and reduce costs. Effective January 1, 2011. (Title III, Subtitle A, Part 3, Sec. 3021)	No changes made.
Demonstration Programs and New Delivery Models		
Accountable Care Organizations	Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. • ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others)	No changes made.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
	• ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. • Offers the Secretary the flexibility to consider a partial capitation model (where the ACO is at financial risk for some, but not all, services) or other payment models, including those used by private payors. • Shared savings program effective January 1, 2012. (Title III, Subtitle A, Part 3, Sec. 3022)	
Medical Homes	Creates a program to establish and fund the development of community health teams to support the development of medical homes for persons with chronic conditions by increasing access to comprehensive, community-based, coordinated care. Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016. (Title III, Part 3, Subtitle F, Sec. 3502) Provides States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. Provides states taking up the option with 90 percent FMAP for two years. Effective January 1, 2011. (Title II, Subtitle I, Sec. 2703)	No changes made.
Independence at Home Demonstration Program	Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes. Effective January 1, 2012. (Title III, Subtitle A, Part 3, Sec. 3024)	No changes made.
Implementation of Medication Management Services in Treatment of Chronic Disease	Establishes a new program to implement medication therapy management (MTM) services provided by licensed pharmacists as part of a collaborative approach to the treatment of chronic diseases with the aim of improving quality of care and reducing overall costs of care in the treatment of such diseases. Requires an annual comprehensive medication review by a licensed pharmacist or other qualified provider and follow-up interventions based on the findings of the annual review. Also requires the prescription drug plan sponsor to have a process in place to assess the medication use of individuals who are risk but not enrolled in the MTM program, including individuals who have experienced a transition in care. Plans must also enroll beneficiaries who qualify on a quarterly basis with an opt-out provision. Effective May 1, 2010. (Title III, Part 3, Subtitle F, Sec. 3503)	No changes made.
Community-Based Care Transitions Program	Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. Effective January 1, 2011. (Title III, Subtitle A, Part 3, Sec. 3026)	No changes made.
Medicare Hospice Concurrent Care Demonstration Program	Directs the Secretary to establish a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The demonstration would be conducted in up to 15 hospice programs in both rural and urban areas and would evaluate the impacts of the demonstration on patient care, quality of life and spending in the Medicare program. (Title III, Subtitle B, Part 3, Sec. 3140)	No changes made.
Patient Navigator Program	Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients in overcoming barriers to health services. Program facilitates care by assisting individuals in coordinating health services and provider referrals; and assists community	No changes made.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
	organizations in helping individuals receive better access to care, providing information on clinical trials, and conducting outreach to health disparity populations. Authorizes $3.5 million for FY2010 and allocating funds as needed for FY2011 through FY2015. (Title III, Part 3, Subtitle F, Sec. 3510)	
Payment Reform – Bundling	Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. • Covers Medicare beneficiaries who are hospitalized for one of ten conditions (a mix of chronic and acute) • Requires the Secretary to establish this program by January 1, 2013 for a period of five years • Before January 1, 2016, the Secretary is also required to submit a plan to Congress to extend the pilot program if doing so will improve patient care and reduce spending. (Title III, Subtitle A, Part 3, Sec. 3023) Establishes a demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid. The demonstration will begin by January 1, 2012 through December 31, 2016. (Title II, Subtitle I, Sec. 2704)	No changes made.
Extension of Special Needs Plan (SNP) Program	Extends the SNP program through December 31, 2013 and requires SNPs to be National Committee for Quality Assurance (NCQA) approved. • Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations • Requires HHS to transition beneficiaries to a non-specialized Medicare Advantage plan or to original fee-for-service Medicare who are enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013 • Also requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations. (Title III, Subtitle C, Sec. 3205)	No changes made.
Medicare Senior Housing Plans	Allows demonstration plans that serve residents in continuing care retirement communities to operate under the Medicare Advantage program. Effective January 1, 2010. (Title III, Subtitle C, Sec. 3208)	No changes made.
New Benefits Supporting Care Coordination		
Medicare Coverage of Annual Wellness Visit	Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. • Such services would include a comprehensive health risk assessment • A personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; and health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition. • Effective January 1, 2011. (Title IV, Subtitle B, Sec. 4103)	No changes made.

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3. Improve Medicare Part D Access and Reduce the Medication Cost Burden		
Reduction or Elimination of the Coverage Gap in Medicare Part D	Increases the initial coverage limit in the standard Part D benefit by $500 for 2010, thus decreasing the time that a Part D enrollee would need to be in the coverage gap. This provision applies only to 2010; the initial coverage limit for subsequent years will be separately determined. (Title III, Subtitle D, Sec. 3315)	This section was repealed by the Reconciliation Bill. (Title I, Subtitle B, Sec. 1101)
Medicare Coverage Gap Discount Program	Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. (Title III, Subtitle D, Sec. 3301)	This section is further amended to include: • Provides a $250 rebate to Medicare beneficiaries who reach Part D coverage gap in 2010 (Effective January 1, 2010) • Gradually phases down the coinsurance rate in the Medicare Part D coverage gap from 100 percent to 25 percent by 2020 • For brand name drugs, requires pharmaceutical manufacturers to provide a 50 percent discount on prescriptions filled in the coverage gap (Effective January 1, 2011), in addition to federal subsidies of 25 percent of the brand-name drug cost by 2020 (Phased in beginning January 1, 2013) • For generic drugs, provides federal subsidies of 75 percent of generic drug cost by 2020 for prescriptions filled in coverage gap (Phased in starting in 2011) (Title I, Subtitle B, Sec. 1101)
Improved Assistance to Low-Income Subsidy (LIS) Beneficiaries	The following sections improve access to Medicare Part D plans for LIS beneficiaries and beneficiary outreach and education activities. • Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a $0 premium LIS plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3303) • Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3304) • Requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3305) • Provides $45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment beginning FY2009. (Title III, Subtitle D, Sec. 3306)	No changes made.

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Elimination of Part D Cost-Sharing for Selected Non-Institutionalized Dual Eligible Individuals	Eliminates Part D cost sharing for people receiving care under a home and community-based waiver who would otherwise require institutional care. (Title III, Subtitle D, Sec. 3309)	No changes made.
4. Enhancing and Revitalizing the Health and Supportive Service Workforce		
Demonstration Project to Address Health Professions Workforce Needs	• Establish a demonstration program to offer low income individuals the opportunity to obtain training and education for occupations in the health care field that are expected to experience labor shortages or be in high demand. • Requires the Secretary to establish demonstration programs in up to 6 States for no less than 3 years through competitive grants for purposes of developing core competencies, pilot training curricula, and develop certification programs for personal and home care aides. • Appropriates $85 million for 5 years (FY 2010-2014), no more than $5 million per year (FY 2010-2012) allocated for the personal and home care aide demonstration (Title V, Subtitle F, Sec. 5507)	No changes made.
Training Opportunities for Direct Care Workers	Establishes grants to eligible entities to provide advanced training opportunities for direct care workers employed in long-term care settings (including nursing homes, assisted living facilities, intermediate-care facilities, and home and community-based settings). • Funds are to be allocated in the form of tuition or fee support for eligible individuals • A condition of receiving assistance is that participating individuals agree to work in the fields of geriatrics, disability services, long term services and supports, or chronic care management for at least 2 years following completion of training • This provision authorizes $10 million for FY 2011-2013 for these grants. (Title V, Subtitle D, Sec. 5302)	No changes made.
Expanding Physician Assistants' Role in Medicare	Authorizes physician assistants to order skilled nursing facility care. This provision is effective starting January 1, 2011. (Title III, Subtitle B, Part 1, Sec. 3108)	No changes made.
Payment Incentives for Selected Primary Care Services	Increases the Medicare payment rate by 10 percent to primary care practitioners for primary care services. • Primary care practitioners are those with a family, internal, geriatric, or pediatric medicine and for whom primary care services account for at least 60 percent of allowed charges (Effective FY 2011-2016). (Title V, Subtitle F, Sec. 5501)	No changes made.
Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education	Authorizes $10.8 million for FY 2011 to FY 2014 for geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools, direct care workers, and family caregivers. • Funds are allocated to develop curricula and best practices in geriatrics focusing on mental health, medication safety, and communication skills in dementia care • These funds also expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; create a parallel geriatrics career incentive award program for Master's level candidates; and establish traineeships for individuals who are	No changes made.

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	preparing for advanced education nursing degrees in geriatric nursing. (Title V, Subtitle D, Sec. 5305)	
Health Workforce Evaluation and Assessment	• Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. Appointments to be made by September 20, 2010. (Title V, Subtitle B, Sec. 5101) • Codifies existing national center and establishes several state and regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies collecting labor and workforce data and coordinate and provide analyses and reports on Title VII to the Commission. Authorizes $7.5 million for each fiscal year 2010 through 2014 to carry out activities of the National Center. Also authorizes $4.5 million for each fiscal year 2010 through 2014 to carry out the activities of the state and regional centers. (Title V, Subtitle B, Sec. 5103)	No changes made.
5. Strengthening Quality and Consumer Protections		
Improving Transparency of Information on Skilled Nursing Facilities, Nursing Facilities, and Other Long-Term Care Facilities		
Required Disclosure of Ownership and Additional Disclosable Parties	Requires skilled nursing facilities (SNFs) and nursing facilities (NFs) to disclose information on ownership and facility organizational structure and requires the Secretary of HHS to develop a standardized format for such information within two years of date of enactment. Final regulations must be promulgated within 2 years following the enactment of this Act. Information will be publicly available one year following the publication of final regulations. (Title VI, Subtitle B, Part 1, Sec. 6101)	No changes made.
Accountability Requirements for SNFs and NFs	Requires SNFs and NFs to operate compliance and ethics programs on or after the date that is 36 months after enactment. Directs the Secretary to develop a quality assurance and improvement program for SNFs and NFs no later than December 31, 2011. (Title VI, Subtitle B, Part 1, Sec. 6102)	No changes made.
Nursing Home Compare Medicare Website	Directs the Secretary to publish the following information on the Nursing Home Compare Medicare website: standardized staffing data, links to state internet websites regarding state survey and certification programs, the model standardized complaint form, a summary of substantiated complaints, and the number of adjudicated instances of criminal violations by a facility or its employee. Each informational element shall be published on the website one year after the date of enactment of the relevant subsection of the bill. (Title VI, Subtitle B, Part 1, Sec. 6103)	No changes made.
Reporting of Expenditures	Requires SNFs to separately report expenditures for direct care staffing services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods. • Requires Secretary to redesign the SNF cost report to meet the needs of this section no later than 1 year following enactment • Effective on or after two years following redesign of the cost report. (Title VI, Subtitle B, Part 1, Sec. 6104)	No changes made.

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Standardized Complaint Form	Directs the Secretary to develop a standardized complaint form for use by residents or a person acting on a resident's behalf in filing complaints with a State survey and certification agency and a State long-term care ombudsman program. • States would also be required to establish complaint resolution processes. • Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6105)	No changes made.
Ensuring Staffing Accountability	Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff. Effective two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6106)	No changes made.
GAO Study and Report on Five-Star Quality Rating System	Requires the Government Accountability Office to conduct a study on the Five-Star Quality Rating System which would include an analysis of the systems implementation and any potential improvements to the system. A Report to Congress is due two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6107)	No changes made.
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes	Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas: • To identify best practices in facilities that are involved in the "culture change" movement, including the development of resources where facilities may be able to access information in order to implement culture change; and • To develop best practices in information technology that facilities are using to improve resident care. • The demonstration projects shall be implemented no later than one year following the date of enactment of this Act. The demonstration projects shall be conducted for a period not to exceed three years. (Title IV, Subtitle B, Part 2, Sec. 6114)	No changes made.
Dementia and Abuse Prevention Training	Permits the Secretary to require SNFs and NFs to conduct dementia management and abuse prevention training in pre-employment training programs, and, if the Secretary determines appropriate, as part of ongoing training. Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 3, Sec. 6121)	No changes made.
Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers	Establishes a national program for long term care facilities and providers to conduct screening and criminal and other background checks on prospective direct access patient employees. Authorizes an amount not to exceed $160 million for the period FY2010 to FY2012. (Title IV, Subtitle C, Sec. 6201)	No changes made.
Other Quality Provisions		
Elder Justice	Establishes advisory capacity and grants to further elder justice providing for the following: • An Elder Justice Coordinating Council within the Office of the Secretary that will make recommendations to the Secretary, coordinating with the Department of Justice and other	No changes made.

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	relevant federal, state, local, and private agencies and entities related to elder abuse, neglect, exploitation and other crimes against elders • Establishes an Advisory Board on Elder Abuse, Neglect and Exploitation to create strategic plans around elder justice in long-term care • Grants to eligible entities to establish elder abuse, neglect and exploitation forensic centers • Awards grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. (Title VI, Subtitle H, Sec. 6703)	

For more information contact:
The SCAN Foundation
Lisa R. Shugarman, Ph.D., Director of Policy
Gretchen E. Alkema, Ph.D., Vice President, Policy & Communications
3800 Kilroy Airport Way, Suite 400, Long Beach, CA 90806
Phone: (888) 569-7226
Email: info@thescanfoundation.org
www.thescanfoundation.org