ACA UPDATE: Opportunities for the Aging Network

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The *Affordable Care Act* and the Aging Network

- The Patient Protection and Affordable Care Act (also known as the Affordable Care Act, or the ACA) is best known for fixing broken health insurance laws and helping to cover millions of previously uninsured Americans.
- What many people don't know is all of the ways the new law is also reducing costs while improving the experience of being a patient, being a caregiver, and being a health care provider.
- Through different demonstration and programs authorized by the ACA, there are opportunities for the aging network to be full partners in reforming our health care system
  - Delivery system redesign
  - Quality
  - Payment reform

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Agenda

- The Center for Medicare and Medicaid Innovation
  - Initiatives
  - Programs and demonstrations
- Medicaid demonstrations
- Medicare services

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Section 3021: Center for Medicare and Medicaid Innovation

- ***I*ncentives**

  Test models that that align payment and administrative approaches that support delivering three part aim outcomes

- ***I*mprovement and Spread**

  Support development and diffusion of three part aim knowledge, models and operational activities

- ***I*deas**

  Drive development of new ways to deliver three part aim outcomes

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CMMI Initial Work and Models

- Partnership for Patients: (1) Patient Safety and (2) Care Transitions
- Bundled Payments for Care Improvement
- ACO: Pioneer and Advanced Payment
- Comprehensive Primary Care Initiative
- Innovation Advisors
- Duals: Skilled Nursing Facility Demonstration (with Medicare-Medicaid Coordination Office)
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration.
- Million Hearts
- Healthcare Innovation Challenge

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Partnership for Patients: Better Care, Lower Costs

Secretary Sebelius has launched a new nationwide public-private partnership to tackle all forms of harm to patients. Our goals are:

1. **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.
   - Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than **60,000 lives saved** over the next three years.
2. **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010.
   - Achieving this goal would mean more than **1.6 million patients would recover** from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Potential to save up to $35 billion dollars over three years.

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Why Is This Important?

- About 1 in 5 Medicare beneficiaries discharged from the hospital are readmitted within 30 days
  - 34% are rehospitalized within 90 days
- Unwanted readmissions have high costs
  - financially for Medicare
  - physically and emotionally for people with Medicare and their families.

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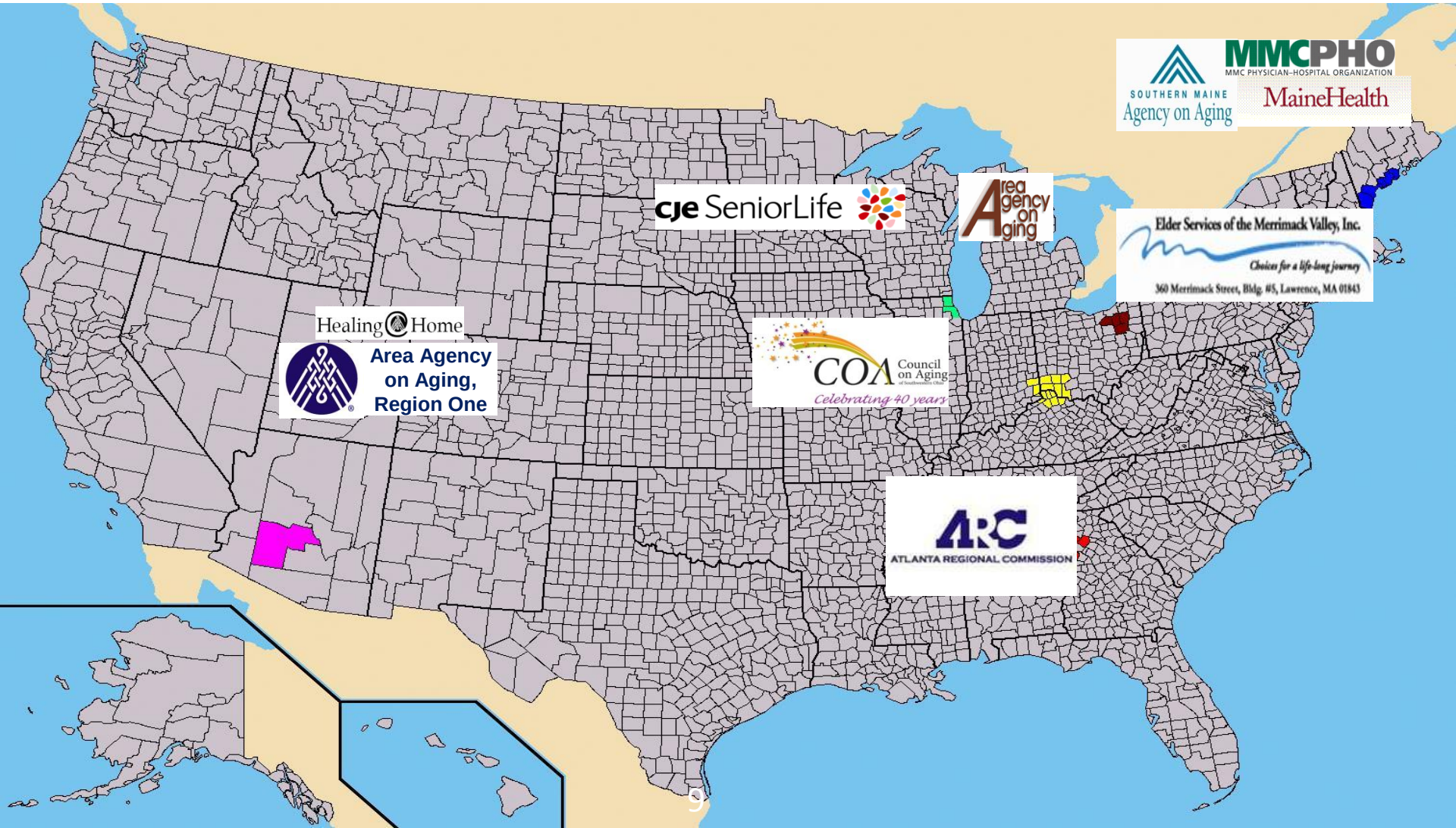
Section 3026: Community-based Care Transition Program (CCTP)

- The CCTP, mandated by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high risk Medicare beneficiaries
- Part of larger Partnership for Patients initiative through the U.S. Department of Health & Human Services

The First CCTP Participants

7 Sites, 9 States, 38 Hospitals, 34,000 Beneficiaries



Million Hearts: *Preventing 1 million heart attacks and strokes in 5 years*

Heart Disease and Strokes are Leading Killers in U.S.

- Cause 1 of every 3 deaths
- Over 2 million heart attacks and strokes each year
  - 800,000 deaths
  - Leading cause of preventable death in people < 65
  - $444 B in health care costs, lost productivity
  - Treatment accounts for ~ $1 of every $6 spent
- Greatest expression of racial disparities in life expectancy

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Community Prevention

Reducing the Number who Need Treatment

- Strengthen tobacco control and reduce smoking
  - Graphic warnings on cigarette packs and ads
  - Community Transformation Grants
- Improve nutrition
  - Decrease sodium and artificial trans fat consumption

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Community Messages: Sign the Pledge!

- **Retailers and Employers**
  - Offer blood pressure monitoring and educational resources; focus on improving ABCS care in retail and worksite clinics
- **Government**
  - Support community and systems transformation to reduce tobacco use and improve nutrition, including smoke-free policies and food procurement standards; provide data for action; expand coverage for the uninsured
- **Advocacy groups**
  - Monitor and demand progress toward goal and promote actions that prevent heart attacks and strokes
- **Individuals**
  - Know your numbers—and goals
  - Take aspirin, if advised
  - Get aggressive with BP and Cholesterol
  - Cut sodium and trans-fats
  - If you smoke, quit

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Section 3022: Medicare Shared Savings Programs and ACOs

- Also known as the ACO – Accountable Care organization -- provision
- Reward ACOs that take responsibility for the costs and quality of their care for Medicare beneficiaries over time
- Savings shared between ACO and Medicare
- Rules have been published and details announced about ACO Models:
  - Pioneer ACO
  - Advance Payment Model

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Section 3024: Independence at Home Demonstration

- Establishes a payment incentive and service delivery system utilizing physician and nurse practitioner directed home-based primary care teams that improve health outcomes and reduce expenditures through care coordination in the home.

- Overall goal is to test whether in-home primary care can reduce hospitalizations, hospital readmissions, emergency department visits, etc.
  - Must serve at least 200 eligible beneficiaries
  - Targets beneficiaries with multiple chronic conditions and functional limitations

- Applications or Letters of Intent (as appropriate) are due to CMS by February 6th

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Section 2602: Federal Coordinated Healthcare Office -or- Medicare-Medicaid Coordination Office

The mission of the Medicare-Medicaid Coordination Office is to:

- Ensure Medicare-Medicaid enrollees have full **access** to the services to which they are entitled.
- Improve the **coordination** between the federal government and states.
- Develop **innovative** care coordination and integration models.
- Eliminate financial **misalignments** that lead to poor quality and cost shifting.

http://www.cms.gov/medicare-medicaid-coordination/

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Current and Ongoing Work within the Coordination Office

- The Medicare-Medicaid Coordination Office is working on a variety of initiatives to improve access, coordination and cost of care for Medicare-Medicaid enrollees in the following areas:
    - Program Alignment –29 misalignments published in the Federal Register-public notice for comments closed 7/11/11
    - Data and Analytics
    - Models and Demonstrations (through partnership with the Innovation Center)

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Medicaid Demonstrations

- Section 2401: Community First Choice
- Section 2403: Money Follows the Person
- Section 2703: Health Homes
- Section 10202: Balancing Incentives Program

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Section 2401: Community First Choice Option

- Adds Section 1915(k)
- Optional State Plan benefit to offer Attendant Care and related supports in community settings, providing opportunities for self-direction
- Does not require institutional LOC under 150% FPL
- Includes 6% enhanced FMAP

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Section 2401: Community First Choice Option (cont'd)

Implementation status

- Notice of Proposed Rulemaking published February 25, 2011 – Comment period closed April 26, 2011
- Final regulation coming soon

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Section 2703: Health Homes for Individuals with Chronic Conditions

- States are able to offer health home services for individuals with multiple chronic conditions or serious mental illness effective January 1, 2011
- Coordinated, person-centered care
- Primary, acute, behavioral, long term care, social services = whole person
- Enhanced FMAP (90%) is available for the health home services (first 8 quarters)

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Section 2703: Health Homes for Individuals with Chronic Conditions (cont'd.)

Implementation Status

- Two states are actively implementing Health Homes (MO, RI)
- Draft Health Home State Plan Amendments have been submitted by 4 other States (North Carolina, Iowa, New York, Utah).
- Resources, state materials, data, sample templates, FAQs for Health Homes are available at the Integrated Care Resource Center: http://www.integratedcareresourcecenter.com/healthhomes.aspx

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Section 2403: Money Follows the Person

- Now extends through 2019-transitions individuals from institutions to community based care and adds resources to balance LTC
- Enhanced Federal match for community services for first year following transition from facility
- 43 States and the District of Columbia now participating in the demonstration

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Section 10202: Balancing Incentive Program

- Designed to help states balance their system of long-term services and supports (LTSS)

- $3B awarded through increased Federal matching payments of 2% or 5% to States that:
  - Currently spend less than 50% or less than 25% of long-term care budgets on home and community-based services (HCBS)

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Section 10202: Balancing Incentive Program (cont'd)

- Participating States must commit to three structural changes:
  - Implement a No Wrong Door/Single Entry Point system
  - Use a Core Standardized Assessment Instrument
  - Implement Conflict Free Case Management standards

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Medicare Services

- Section 3301: Medicare coverage gap discount
- Section 4103: Medicare annual wellness visit
- Sec 3204: Simplification of annual beneficiary election periods
- Sec 4104: Waiving coinsurance for preventive services

Section 3301: Medicare coverage gap discount

- Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased in the coverage gap beginning January 1, 2011 in order for manufacturers' drugs to be covered under Medicare Part D.
- In addition, Medicare will begin providing additional coverage for brand and generic drugs in 2013, so that by 2020 the donut hole will be closed.

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Section 4103: Medicare annual wellness visit

- Provides Medicare coverage, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. The 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; 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.
- Coverage began in January
- Some issues re: beneficiary and provider understanding of what is included in this benefit

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Sec 3204: Simplification of annual beneficiary election periods

- Part C&D enrollment period to begin 10/15 – 12/7
- Related: Medicare Advantage disenrollment period: People enrolled in private Medicare Advantage plans now have a 45-day window (from January 1 to February 14 of each year) in which they may return to Original Medicare (Parts A and B) and also enroll in a stand-alone Part D prescription drug plan if they wish.

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Sec 4104: Waiving coinsurance for preventive services

- Removal of Medicare Coinsurance and Deductible for preventive services:
  - abdominal aortic aneurysm screening
  - bone mass measurement
  - breast cancer screening/mammograms
  - cardiovascular screening tests (although you generally will have to pay 20% of the Medicare-approved amount for the doctor's visit)
  - certain types of colorectal cancer screenings (i.e., flexible sigmoidoscopy and colonoscopy)
  - diabetes screening tests (although you generally will have to pay 20% of the Medicare-approved amount for the doctor's visit)
  - flu shots
  - Hepatitis B shots
  - HIV screening tests (although you generally will have to pay 20% of the Medicare-approved amount for the doctor's visit)
  - medical nutrition therapy services (for those with diabetes or kidney disease, or who have had a kidney transplant in the last 36 months and whose doctor refers them for these services)
  - Pap tests and pelvic exams
  - physical exams – both the "Welcome to Medicare" visit and the annual "wellness visit"
  - pneumococcal shot
  - prostate cancer screening
  - smoking cessation counseling

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AoA Contacts and Resources

- AoA Health Reform Page: http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx
  - Highlighted programs
  - Webinars
  - Toolkit
- AoA ACA Emailbox: AffordableCareAct@aoa.hhs.gov
- Abigail.Morgan@aoa.hhs.gov

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