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National Senior Citizens Law Center

Protecting the Rights of Low-Income Older Adults

A collage of several photographs of elderly people, including a woman smiling, a woman holding a baby, an elderly man, and two elderly women, all in a light blue tint.

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Protecting the Rights of Low-Income Older Adults

The National Senior Citizens Law Center
advocates nationwide to promote the
independence and well-being of
low-income elderly and disabled Americans.

How Health Reform will Impact Low-Income Older Adults

- Topics
 - Medicaid Long-Term Services and Support provisions
 - Changes affecting low-income Medicare enrollees and dual eligibles
 - New protections for nursing facility residents and older individuals generally
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June 23, 2010

Health Care Reform and the Aging Population

Medicaid Long-Term Services and Support provisions

Gene Coffey, National Senior Citizens Law Center
NCLC Webinar

Medicaid LTSS Provisions in Health Reform

- State Balancing Incentive Program
- Community-First Choice Option
- Improvements to HCBS State Plan Benefit
- Extension of and improvements to Money Follows the Person Program
- Mandatory application of spousal impoverishment protections to HCBS enrollees



State “Balancing Incentive” Program

- Section 10202 of PPACA: Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes
- States spending less than 50% of their Medicaid LTSS dollars on HCBS may be selected to receive enhanced FMAP for all Medicaid HCBS services during “balancing incentive period” of October 1, 2011 through September 30, 2015
- Most states are eligible for participation. See “A Balancing Act: State Long-Term Care Reform,” AARP Public Policy Institute (2008)



State “Balancing Incentive” Program, continued

- States that directed <25% in FY 2009 eligible for 5 point FMAP increase and must aim to reach 25% by end of balancing incentive period
- States that directed between 25% and 50% in FY 2009 eligible for 2 point FMAP increase and must aim to reach 50% by end of balancing incentive period
- State applications must contain details of how states will expand access to community-based services
- No penalties identified in statute; CMS will be responsible for ensuring state commitment
- No cap on number of states that may participate, although federal financing authorization limited to \$3 billion
- States must comply with maintenance-of-effort (MOE) requirement that may be broader than current American Reinvestment and Recovery Act MOE



Community First Choice Option

- Section 2401 of the PPACA: Community First-Choice Option
- Provides states the financial incentive to make attendant services an unconditional option for individuals who meet their states' standards of need for institutional care
- Beneficiaries will receive attendant services necessary to assist them in accomplishing activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Benefit also includes:
 - Assistance in acquiring, maintaining and enhancing skills necessary to accomplish ADLs and IADLs
 - Consumer direction mandates
 - Express allowance for family members to provide services
 - Transition-related services



Community First Choice Option, continued

- Eligibility
 - Benefit available exclusively to individuals who, in the absence of the benefit, would require the level of care provided in a hospital, nursing facility, ICF-MR, or institution for mental diseases
 - Limited to individuals whose income is at or below 150% of the federal poverty level (FPL), or, if greater, the state's nursing facility income limit (the maximum limit being 300% of the Supplemental Security Income benefit rate)



Community First Choice Option, continued

- States receive six percentage point increase in FMAP for services covered under benefit
- States may not limit the number of individuals receiving coverage for the benefit
- States must make benefit available statewide and may not target the benefit
- States must establish “Development and Implementation Council” that includes majority of members with disabilities, elderly individuals, and must consult and collaborate with Council in adoption of the benefit
- States may make benefit available October 1, 2011



Improvements to HCBS state plan benefit

- Section 2402(b) of the PPACA: Removal of Barriers to Providing Home and Community-Based Services
- Home and Community-Based Services state plan benefit
 - Authorized by Deficit Reduction Act of 2005 (DRA)
 - Must be made available to individuals who do not meet state's Medicaid LTC standard
 - Five states have incorporated benefit into their Medicaid programs: Iowa, Nevada, Colorado, Washington, and Wisconsin



Improvements to HCBS state plan benefit, continued

- Changes and additions to HCBS benefit
 - Changes:
 - State authority to cap the number of individuals receiving coverage for benefit and limit coverage to select areas of state deleted
 - Services that may be included in benefit expanded to include any services CMS authorizes
 - Protection for Medicaid beneficiaries who receive coverage for the benefit before state modifies its clinical eligibility standard extended beyond 12 month maximum in original statutory language
 - Additions
 - States may make HCBS benefit recipients separate categorical population
 - States may offer enhanced HCBS benefit to individuals otherwise eligible for HCBS waiver
 - States may target the HCBS state plan benefit



Money Follows the Person

- Section 2403 of the PPACA: Money Follows the Person Rebalancing Demonstration
- Background
 - In the DRA, Congress authorized \$1.7 billion to support state efforts to transition Medicaid-enrolled nursing facility residents to the community
 - 30 states awarded “grants” ranging from \$5 million to \$140 million. Grants come in the form of enhanced FMAP for HCBS services provided to MFP participants
 - DRA authorized program through end of FY 2011
- Changes
 - Authorization extended through end of FY 2016
 - Minimum institutional residency eligibility requirement reduced from 6 months to 90 days



Spousal Impoverishment Protections and HCBS

- Section 2404 of PPACA: Protection for Recipients of Home and Community-Based Services against Spousal Impoverishment
- Current language of 42 U.S.C. §1396r-5(h)(1)(A)
 - The term “institutionalized spouse” means an individual who “is in a medical institution or nursing facility or who (at the option of the state) is described in 1396a(a)(10)(A)(ii)(VI)”
- The change to 42 U.S.C. §1396r-5(h)(1)(A):
 - Between January 1, 2014 and December 31, 2019, the provision shall be read as follows: The term “institutionalized spouse” means an individual who “. . . is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being eligible under section 1902(a)(10)(C) or by reason of section 1902(f) . . . , or who is eligible for medical assistance for home and community-based attendant services and supports under 1915(k).”



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Health Care Reform and the Aging Population

Changes Affecting Low Income Medicare Enrollees and Dual Eligibles

Georgia Burke, National Senior Citizens Law Center
NCLC Webinar

Medicare Part D

Closing the donut hole in Medicare Part D

- 2010: \$250 checks- tax free, not for LIS, not for employer plans with retiree drug subsidy.
- 2011: 50% rebate on prescriptions, 7% on generics
- 2012- 2020: Full closing of the hole until beneficiary pays 25% of drug cost or actuarial equivalent
- Gradual lowering of threshold for start of catastrophic coverage



Medicare Part D

Other Part D changes

- \$0 co-pay for some duals receiving HCBS in the community (2012 or later).
- Reassignment improvements for LIS beneficiaries (2011)
 - Benchmark calculations that exclude MA rebates are codified
 - Plans losing benchmark status can waive de minimis premiums
 - LIS reassignment notices will explain changes in drug coverage
- Extra year of LIS eligibility for surviving spouse (2011)
- New annual enrollment period: Oct 15 –Dec. 7 (Fall 2011)
- Uniform exceptions and appeals processes (2012); improved complaint tracking by CMS
- Medication Therapy Management for targeted individuals w/ opt-out (2013)
- Free generic first fill option (2011 or later)
- Including ADAP/IHS payments in TrOOP (2011)
- Codification of six protected classes of drugs



Changes in Medicare Managed Care

- Payments to plans
 - Lower overall, formula related to county FFS costs, rural plans may get relatively higher payments (2011)
 - Star rating bonuses (2012)
 - 85% medical loss (2014)
- Prohibits higher cost sharing than FFS for chemo, dialysis, skilled nursing, others (2011)
- MA disenrollment period—January 1-February 14 each year (Jan. 2011)
- Special Needs Plans reauthorized through 2014. Must get approval of National Committee for Quality Assurance by 2012. D-SNPs have until 2013 to contract with state Medicaid agencies.

Expect a shakeout

Changes in plan design

Plans exiting the market

Quality emphasis?



Dual Eligibles

- Federal Coordinated Health Care Office (2010)
 - “Office of duals”
 - Improve beneficiary experience
 - Integration and coordination of care
 - Other duals issues



Dual Eligibles

- Center for Innovation (2011)
 - Medicare alone/Medicaid alone/interaction of both/CHIP
 - Test payment reform models
 - Improve quality and slow rate of cost growth
 - 20 models
 - Combined payment stream
 - Capitated risk
 - Fully integrated care for duals
 - State waivers



Dual Eligibles

- Innovation and integration bring opportunities and challenges
 - Beneficiary centered process
 - Choosing appropriate models
 - Ensuring readiness
 - Retaining beneficiary protections
 - Preserving benefit levels
 - Effective stakeholder input at the local, state, and federal levels



General Medicare Provisions

- CMS to collect racial, ethnic and language data
 - Uniform data categories
- More funding for SHIPs, AAAs and ADRCs
- Demos and pilots for improving care
- More coverage of preventive health
 - Free annual physical
 - No cost sharing for certain preventive services



Integrating senior benefits with other parts of health reform

- Medicaid expansion-
 - ❖ Under 65, 133% FPL, no asset test
 - ❖ Exchange with subsidies

Transition issues for those turning 65

- Web portals
 - ❖ Federal portal for exchange and state benefit programs (2010)
 - ❖ State portal for benefit programs-web, phone, walk-in (2014)

How to make portals accessible to frail older adults

Language access, disability access

How to integrate senior programs



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June 23, 2010

Health Care Reform and the Aging Population

Protection for Nursing Home Residents and Older Persons Generally

Eric Carlson, National Senior Citizens Law Center
NCLC Webinar

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- **EXISTING BILLS FOLDED INTO LEGISLATION**
 - Elder Justice Act
 - Nursing Home Transparency and Improvement Act
-

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- **INFORMATION DISCLOSURE
& QUALITY OF CARE**
-

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- What is the relationship between quality and disclosure?
-

Disclosure of Information Re: Ownership, Management

- Facility must disclose info on “each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service.”
- Must describe legal interrelationships between entities and real persons that own or manage facility.



Disclosure: Implementation

- Implementing regulations by March 2012.
 - Facilities to submit info by June 2012.
 - Info available to consumers by March 2013
- **EFFECTIVE IMMEDIATELY**, same info available upon request to federal and state governments, and each state's long-term care ombudsman program.



Standardized Complaint Form

- CMS develops standardized form for filing complaint to state survey agency or ombudsman program.
 - Effective March 2011.
 - Not meant to prevent complaints from being submitted orally and in other formats.



Complaint Resolution Process

- Each state must develop complaint resolution process.
 - Tracking of complaints.
 - Investigation procedures.
 - Notification to complainants.
- Prevent retaliation against family members or friends who file complaints.
- Effective March 2011.



Nursing Home Compare: More Information by March 2011

- Staffing data.
 - Hours of care per resident per day.
 - Turnover and tenure.
- Links to state websites with information regarding State survey and certification programs.
- Standardized complaint form (as discussed above).
- Instructions on how to file complaint with survey agency or state long-term care ombudsman program.
- Summary information on the number, type, severity, and outcome of substantiated complaints.
- Criminal violations by nursing facility or employees.



Evaluate, Improve Nursing Home Compare

- Review accuracy, clarity, timeliness, and comprehensiveness.
 - Consult with ombudsman programs, consumer advocacy groups, provider stakeholder groups, and others.
 - Revisions made by March 2011.
- To improve timeliness of website's information, states provide inspection information to CMS at same time info is presented to facilities.
 - CMS must update info on Nursing Home Compare at least quarterly.



Five Star Quality Rating System: Study Required

- Ratings from 1 to 5 stars based on:
 - Inspection records.
 - Staffing levels.
 - Quality measures.
- Providers have complained about accuracy, fairness.
- GAO must study and submit report to Congress.
 - Findings and recommendations by March 2012.



State Websites

- Each state must have consumer-oriented website with info re: each of state's nursing facilities.
 - Must include inspection results & corresponding plans of correction.



Availability of Inspection Reports

- Inspection reports from previous three years available at facility upon request.
 - Must post notice of reports' availability in prominent place within facility.



Accurate Reporting of Staffing Data

- Facilities submit direct-care staffing levels electronically to CMS.
 - Type of employees – nurse, nurse aide, etc.
 - Resident census and care needs.
 - Turnover & tenure.
- Separate out temporary employees.
- Based on auditable data like payroll.
- Effective by March 2012.
 - To develop procedures, CMS must consult with ombudsman programs, consumer advocacy groups, provider stakeholder groups, and employees and unions.



Enforcement

- Supplementing existing provisions relating to violations and remedies.
 - Long-standing system for enforcing Nursing Home Reform Law.



Reductions for Self-Reported Violations

- Authorizes CMS to reduce money penalty against nursing facility by up to 50 percent if
 - Self-reports violation.
 - Corrects deficiency within ten days.
- Reduction not available if
 - Penalty for same violation reduced within preceding year, or
 - Deficiency had caused pattern of harm, immediate jeopardy, or death.



Appealing Penalties

- For all civil money penalties, independent dispute resolution process available.
- CMS given authority to require money penalties be put into escrow account as they accrue.
- Effective by March 2011.



Use of Penalty Amounts

- Some portion of collected penalty amounts may be used to support activities that benefit residents.
 - E.g., Protection of residents when facilities close.
 - Promotion of resident and family councils.
 - Facility-focused initiatives:
 - Joint training of facility staff and surveyors.
 - Technical assistance for facilities implementing quality assurance programs.
 - Temporary managers.
- Effective by March 2011.



Oversight of Chains: Voluntary Demonstration Project

- CMS and the HHS Inspector General with demonstration project for independent monitor program overseeing nursing facility chains.
 - Nine chains FROM THOSE THAT APPLY.
 - Selection based in part on existing quality of care problems.
- Program for two years, starting by March 2011.
- Facility responsible for cost of monitor.
- Detailed analysis of chain's operation.
- Monitor submits recommendations to chain, which must report within 10 days how the chain will implement the recommendations, or why it will not.



Nursing Facility Closures

- Facility must provide written notice at least 60 days before scheduled voluntary closure.
 - Notice provided to CMS;
 - Ombudsman program; &
 - Residents and their representatives.
- Notice must include plan for transfer of each resident.
- Violation subjects administrators to civil monetary penalties of up to \$100,000 and exclusion from federal health care programs.



Surveyor Training

- CMS contracts with entity to establish National Training Institute for federal and state surveyors.
 - Training and technical assistance.
 - Develop best practices.
 - Analyze complaints and investigations.



Reporting of Crimes

- Mandating reporting in any long-term care facility that annually receives at least \$10,000 in federal funding.
 - Obligation on managers and employees.
- If reasonable suspicion of crime committed against resident, report to CMS and law enforcement.
 - Within 24 hours, or
 - Within 2 hours if crime resulted in serious bodily injury.
- Failure to report resulting in penalties of up to \$200,000 and exclusion from federal health care programs.
 - Additional penalties or retaliation against employee for making report.
- Each long-term care facility must post notice specifying employees' rights.



Hiring & Staff Training

- Importance of staffing to quality of care.



Training in Dementia and Abuse Prevention

- Training in nursing facilities must include training in
 - Dementia care.
 - Abuse prevention.
- Also clarification: nurse aide training requirements apply to agency employees.
- Effective March 2011.



Nationwide Program of Background Checks

- CMS must develop process for nationwide background checks for direct-care employees.
 - Through agreements between CMS and states.
- Used for:
 - Nursing facilities.
 - Home health agencies.
 - Hospice agencies.
 - Adult day health care providers.
 - Assisted living facilities if providing level of care determined by CMS.
 - Other providers as determined by state.



Background Check Details

- Based on fingerprints.
- Must have “rap back” capacity so subsequent criminal convictions are reported to CMS and then to states and LTC employers.
- States must have appeal processes.
 - Passage of time.
 - Extenuating circumstances.
 - Rehabilitation.
 - Relevance of disqualifying event, given person’s current employment.
- Three-quarters federal funding, with non-federal match from each state.



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Questions?

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