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Care Management and the Affordable Care Act (ACA) The Possibilities, The Realities, and The Concerns

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Guest Editor's Message

Carol S. Heape, MSW, CMC, Fellow

*"The Patient Protection and Affordable Care Act (ACA) is the most significant health-care legislation enacted since the passage of Medicare and Medicaid forty-five years ago. The new law's full implications will not be known for years..."*¹

The Affordable Care Act (ACA) is in the news almost daily as its implementation approaches. It is a moving target, with facets and timelines changing in some ways in a domino effect. Regardless of the controversy surrounding this massive legislation, it lumbers forward with changes that already have been in effect for several years i.e., those occurring this fall and more scheduled

to come in future months.

"The bill itself has many components, some of which are complex topics unto themselves and involve multi-year schedules. Some create new federal offices, and others confer authority to pursue goals and concepts, rather than containing specific program proposals. As a result, most people at the community level did not understand the bill or the planning that went into it well enough to be able to clarify it for others."²

For Geriatric Care Managers (GCM), the ACA means one set of issues for their clients, the great majority of whom are on Medicare. However, Geriatric Care Managers are also business owners looking for new opportunities to serve clients and perhaps expand their practice to include other populations. Care Managers are also very aware of the "world at large"

and recognize the complexity of this legislation and how it is predicted to change healthcare as the U.S. knows it. This will also change for them how care management is viewed and how those views will change society's expectations. Finally, whether you, the Geriatric Care Manager are a sole practitioner, consider yourself a small business with several employees, are part of a larger care management firm or healthcare system, or are the founder or owner of a large company offering care management, home care, conservatorship, fiduciary services, etc., you must pay attention! The ACA is large, complex, and has aspects that will affect all Care Managers personally and professionally.

"This legislation is not perfect. Many social workers supported a single-payer system or, at minimum,

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adding a public option to the ACA. Despite this, the legislation provides a critical framework for addressing our nation's healthcare issues."³

Susan Emmer, Legislative Consultant to NAPGCM begins her article, "Care Coordination Under the Affordable Care Act: Opportunities & Challenges for Geriatric Care Managers" with a historical perspective of what care coordination looked like prior to the passage of the ACA in 2010. She brings us forward to the aspects of the ACA that focus on care coordination and describes care management/care coordination programs such as Community-based Care Transitions Program (CTP), Affordable Care Organizations (ACO), Health Care Innovation Awards, Navigator Program, Money Follows the Person, and others. Her article not only explains the terms and a summary of the programs but she offers an encouraging challenge to Geriatric Care Managers to learn about new programs within the changing healthcare landscape that will utilize the expertise and community knowledge of the Care Manager.

Since 2000, Regina Curran, MA, CMC, "A CLASS Act – Development Until the Aftermath of its Demise," has represented NAPGCM in the Leadership Council of Aging Organizations. Curran, with NAPGCM Legislative Consultant Susan Emmer, continues to educate NAPGCM membership about aging policy as well as working to have the NAPGCM voice be heard nationally. Regina writes about national long-term care policy (or lack thereof) after giving us a background on Medicare, Medicaid, the CLASS Act, and the establishment of the Commission on Long-term Care under the ACA by President Obama. This article not only gives Geriatric Care Managers a historical perspective on healthcare legislation but is a strong reminder of how long it takes the Congressional process to effect change. Finally, it reaffirms what Geriatric Care Managers know. The long-term care system continues to

be fragmented with no overall public program in place to address long-term care needs for all older Americans who wish to age in place in their own homes.

Building on Emmer's article on the ways "person-centered care" and care coordination are included throughout various aspects of the ACA, Michael Newell, RN, MSN, "The Affordable Care Act: Shaking Up the System Provides Opportunities for Care Management" writes how the changes occurring prior to the ACA have set the stage for potential involvement and opportunities for Geriatric care managers. Patient-centered care, Newell writes is "care that is respectful of and responsive to individual patient preferences, needs and values." The concept of patient-centered empowers the individual to keep and review their own Personal Health Record brought about through the advent of the HITECH Act and electronic health records (EHR). Although challenges remain, Geriatric Care Managers have already begun working with the EHR with their client. Funding was included with the ACA to facilitate and further reinforce the EHR concept. Newell's article further explains existing and pilot projects and the potential development of opportunities for Geriatric Care Managers around the country to become involved within the contexts of their practice and community/state programs being implemented for care coordination.

"The Affordable Care Act and Its Impact on Care Management," Eric Rackow, MD and Claudia Fine, LSCW, MPH, CMC of Humana Cares/SeniorBridge shows the extent a national care management company within the context of Humana, a national health company, can be an active participant in the public arena. SeniorBridge had participated in several pilot studies, utilizes an interdisciplinary approach within the company (acquired by Human in July 2012), and with the help of proprietary electronic health records is able to track patient outcomes. The work Humana Cares/SeniorBridge is doing is a critical example of how

data collection, statistics, and tracking outcomes can move the profession upward to the point of being recognized as the profession it is. The authors have addressed this shortfall and write an important message to Care Managers about the opportunity to participate with this effort. Through their data collection and development of predictive models, Humana Cares/SeniorBridge has been able to address these issues as well as the 30 day readmission problem. Finally, it brings Geriatric Care Managers back to tracking statistics, diagnoses, and identifying common problems care recipients and Care Managers face together. In conclusion, these authors stress the need for consistent, measurable outcomes that will track the processes and demonstrate a positive outcome.

In her article, Phyllis Brostoff examines the ACA from an employer's perspective, "Beware of What You Wish For OR The Affordable Care Act and Me" anticipating that by 2015, her company will have to comply with the mandates set up for employers with 50 or more full time employees. As a social worker and larger company employer, Brostoff writes of her philosophy of having universal health coverage for everyone. Now however, she is facing the reality of an employer who has offered health insurance as a benefit to employees for some time that now may not be sufficient to comply with the mandates of the ACA. The story is not unfamiliar to many of us who started companies as a sole practitioner, added Care Managers and administrative staff as employees and then made the decision to add the home care component. In her article, Brostoff gives the specifics of the growth of her company, the addition of employees that was fueled by growth and the conflict she encounters as the rules of the ACA pose a fiscal and social conflict. With some of the requirements changing, it will be interesting to see what the requirements end up being for those of us with enough employees with or without health insurance as a current benefit in 2015 when this portion of the ACA be-

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comes effective. The side bar developed by Brostoff should be helpful to readers who are trying to decide how the employer's portion of the ACA will affect them as an employer or as an individual whose spouse/partner may be affected by their employer and healthcare coverage.

The Massachusetts model of health care coverage for its residents was the initial model upon which the ACA was built. In place since 2006, the Massachusetts model has undergone some changes and revisions but continues to build on its success. Natasha Doigin, MD/PhD Candidate and Kate Lapane, PhD write of the state's progression and next steps in Understanding National Health Reform – Why Big Data Isn't Enough – Lessons from Massachusetts Health Reform.

Clients assisted by Geriatric Care Managers are normally on Medicare. Such is the confusion surrounding the ACA that many of our clients are suspicious and unsure of how the implementation of the ACA will affect them. The last article describes some of the ways the ACA will affect the clients Geriatric Care Managers work with daily: "Effects on Medicare Clients & the Affordable Care Act (ACA)." Government sources say Medicare recipients will be affected little by the ACA although Medicare reform within the ACA aim to weed out waste, criminal intent and excess charges while providing a better quality of patient-centered care. These predicted savings are expected to help with other expenditures within the scope of the ACA.

The challenge with this issue of the GCM Journal on the Affordable Care Act was to give readers some

history, explanation, encouragement, and reality while recognizing the challenges. Furthermore, reading the articles enclosed, you will have a better understanding of your role and your future within the healthcare arena. Gone are the days when someone asks you, "What is a Care Manager?" There is a realization that what we do as Geriatric Care Managers matters. We just have to move from the back burner to the front.

Footnotes

- 1 Kaplan, R., "Older Americans, Medicare, and the Affordable Care Act: What's Really In It for Elders?", ASA Generations, Spring 2011, 19-25.
- 2 Browdie, R., "Health Reform, Politics, and Conflict: Is This Any Way to Serve America's Elders?", ASA Generations, Spring 2011, 6-10.
- 3 Gorin, S., "The Affordable Care Act – A Social Work Perspective", Social Work Today, Jan./Feb. 2013, 23-25.

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Care Coordination Under the Affordable Care Act: Opportunities and Challenges for Geriatric Care Managers

Susan Emmer, Esq.

SUMMARY: *The Affordable Care Act (ACA) established multiple care coordination demonstrations, pilots, and programs premised on quality and patient-centeredness. This article describes the circumstances preceding enactment of the ACA, summarizes several of the new care coordination elements of the law, and explains the benefits and risks for the geriatric care manager community posed by the ACA's changes.*

Introduction

On March 23, 2010, President Obama signed the Affordable Care Act (ACA) into law (ACA, 2010). In addition to increasing health care access and lowering costs, the ACA's sponsors intended to improve quality and incentivize care coordination across the health system's silos. Currently the nation's health care system is fragmented, providing episodic care with little management of transitions between care delivery points and a disjointed approach to the social components of a patient's case. The ACA aims to improve the delivery system over time such that all facets of the health care system coordinate seamlessly.

In this regard, multiple sections of the ACA include new care coordination programs relevant to geriatric care managers (GCMs). By design, Congress aimed for "better integration of care, better designed services . . . better measurement tools. These provisions . . . will improve care coordination. [They] better align incentives for quality care and move towards seamless, integrated care." (Berwick, 2010) These new ACA

coordinated care programs are in various stages of implementation but all of them are relevant to GCMs.

Care Coordination Prior to the ACA

Fifteen years ago, policy makers were not focused on care coordination. Although lawmakers agreed that Medicare spending was unsustainable and subject to double or triple growth rates, they focused remedies on episodic care, aiming reforms only at the treatment for a specific disease. Despite agreement that patients with multiple co-morbidities had the highest costs, Congress enacted new programs focusing on disease management and light chronic care management rather than the coordination of care across multiple disciplines. (Crippen, 2002).

Over time, policy makers responded to public demand and increased research that called for better coordination and care for patients with chronic conditions. Studies of ongoing pilots (34 programs) demonstrated that most disease management and care coordination models did not reduce

Fifteen years ago, policy makers were not focused on care coordination. Although lawmakers agreed that Medicare spending was unsustainable and subject to double or triple growth rates, they focused remedies on episodic care, aiming reforms only at the treatment for a specific disease.

Medicare spending because they did not reduce hospital admissions (CBO Issue Brief, 2012). Significantly, programs that concentrated on transitions in care settings relied on team-based care that included a care manager and targeted high-risk enrollees were more likely to reduce costs and improve outcomes (CBO Issue Brief, 2012). The authors of the ACA recognized this and endeavored to harness the cost-saving attributes of coordinated care within the framework of health reform.

Geriatric care managed care in particular, encompass the aforementioned positive, cost-saving, quality- focused characteristics. "Professional geriatric care management is a holistic, client-centered approach to caring for older adults... through: assessment and monitoring, planning and problem-solving, education and advocacy, and family caregiver coaching." (NAPGCM, 2013). GCMs, therefore, have a place in the new care coordination oriented delivery system reforms included in the ACA.

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ACA Care Coordination Provisions

The ACA includes numerous new Medicare and Medicaid demonstrations, pilots, and programs that aim to improve care coordination and transitional care for beneficiaries, including:

Medicare Community-based Care Transitions Program

The Community-Based Care Transitions Program (CCTP) evaluates models for improving care transitions from the hospital to other health care sites, reducing readmissions for high-risk Medicare beneficiaries, and saving Medicare funds (ACA, Sec. 3026). Community-based organizations (CBOs) that partner with hospitals with high readmission rates are the intended grantees. CBOs must have a governing body that includes multiple health care stakeholders, including consumers.

As of March, 2013, the Center for Medicare and Medicaid Services (CMS) has awarded CCTP agreements to 102 sites (CCTP Site Summaries, 2013 and Lind, 2013). Services of note include: post-discharge education, encouraging timely patient interaction with post-acute care providers, and patient/caregiver self-management support (CCTP Solicitation for Application, 2013). Further information about the program, including a list of grantees, can be found at <http://innovation.cms.gov/initiatives/CCTP/>.

Accountable Care Organizations

Accountable Care Organizations (ACOs) coordinate physicians, hospitals, and other health care providers who join together to create systems that holistically provide care to Medicare beneficiaries. If ACOs improve outcomes and reduce costs, they can share the program savings (ACA, Sec. 3022). As of July 1, 2013,

164 ACOs provided care to Medicare beneficiaries across the nation.

ACO models are diverse, but there are multiple variations that include special benefits, such as end-of-life services that might be of interest to GCMs (ACO Model Summaries, 2013). Further information about the program, including a list of the three ACO sub-types and grantees, can be found at <http://innovation.cms.gov/initiatives/ACO/>.

The Health Care Innovation Awards are awarding up to \$1 billion to applicants across the country that test new payment and service delivery models for improving quality and lowering costs for enrollees in Medicare, Medicaid, and/or the Children's Health Insurance Program (ACA, Sec. 3021).

Initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents

CMS will work with non-nursing facility organizations to implement evidence-based interventions that reduce avoidable hospitalizations and improve outcomes in at least 15 nursing facilities for Medicare and Medicaid beneficiaries (ACA, Sec. 3012). Eligible organizations may include physician practices, care management organizations, and other entities. Seven organizations were selected for this initiative (Initiative Model Summaries, 2013). Further information about the program can be

found at <http://innovation.cms.gov/initiatives/rahnfr/>.

Health Care Innovation Awards

The Health Care Innovation Awards are awarding up to \$1 billion to applicants across the country that test new payment and service delivery models for improving quality and lowering costs for enrollees in Medicare, Medicaid, and/or the Children's Health Insurance Program (ACA, Sec. 3021). There currently are 107 varied participants, many of which include a care manager on their teams (Health Care Innovation Award Model Summaries). Further information about the program, including a list of grantees, can be found at <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/>.

Navigator Program

Under the Navigator Program, consumers will select new health insurance options through the Health Insurance Exchanges (ACA, Sec. 1311). Some states will establish a State-Based Marketplace, while others will partner with the federal government to create a Federal-State Partnership Marketplace, and a third category of states will use a Federally-facilitated Marketplace (CCIO In Person Assistance with the Health Insurance Marketplace, 2013). The Navigator Program will help consumers to select health insurance from myriad options within two of the three constructs: the federally facilitated exchanges and the state partnership marketplaces.

Navigators will help consumers to prepare applications, determine eligibility, and purchase health insurance through the Marketplaces, and receive financial assistance if eligible. In addition, navigators will educate consumers about the Marketplace, referring consumers to the health insurance ombudsman and consumer assistance liaison when necessary. Navigators must meet stringent guidelines, participate in all types of Marketplaces, be funded through state and federal grant programs, and

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complete comprehensive training. On April 9, 2013, CMS announced a funding opportunity for navigators (CCIO In Person Assistance with the Health Insurance Marketplace, 2013). Further information about the program can be found at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html>

Medicaid Health Homes for Chronic Conditions

States have the option under Medicaid, as amended by the ACA, to establish a Health Home to coordinate care for individuals with multiple chronic conditions or serious mental illness (ACA, Sec. 2703). States may designate a Health Home from among (1) a designated provider; (2) a team that may include nurses as coordinators or social workers; or (3) a health team that must include, among others, nurses and social workers (Medicaid Health Homes, 2013). Further information about the program can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html>

Money Follows the Person

The ACA continued and expanded the Money Follows the Person (MFP) Rebalancing Demonstration (ACA, Sec. 2403). The demonstration assists with the transition from institutional settings to the community. The ACA increased eligibility for the program to include new categories of individuals living in an institution. Currently, 45 states and the District of Columbia have MFP programs (Money Follows the Person, 2013). Further information about the program can be found at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>

If you are a GCM and an NAP-

GCM member and you participate in any of the above programs, please contact the author, NAPGCM staff, or NAPGCM leadership so that NAPGCM can better serve the GCM community's interests. GCMs can reach the author at emmerconsulting@verizon.net. While we understand that most geriatric care managers are not serving as direct grantees, NAPGCM hopes that members will partner or

By design, GCMs employ a global perspective. GCMs open doors, talk to everyone in the health delivery chain, and refuse to see barriers between the clinical and non-clinical sides of patient care. The GCM philosophy meshes with the ACA's coordinated care provisions in a unique way.

contract with grantees to participate in networks or provide limited services to core populations. We hope to compile a database of member involvement which can better inform the NAPGCM understanding of the new programs.

Benefits and Risks for the GCM

Not surprisingly, the passage of the ACA creates both opportunities and challenges for the GCM.

History. Despite recent increased awareness of the care coordination model, GCMs have been in the trenches performing this role since well before NAPGCM was created in 1985 (NAPGCM, 2013). As entrepreneurs, translators, transition specialists, man-

agers, paperwork czars, and "quarterbacks," GCMs have coordinated care before it became a recognized need, term, or was included as a major focus through multiple new programs included in the ACA. GCMs have the experience and skills to participate in the care coordination models and system reform mentioned above.

Demand. There is at least one new delivery system demonstration, pilot, or program in every state with multiple new programs in many states (CMMI Where Innovation is Happening, 2013). As hospitals, health care systems, physician groups, community-based organizations, and other entities implement these new programs, they will need the services of experienced and qualified care managers. If direct participation options are not available, multiple opportunities to be involved still exist through partnering, sub-contracting, consulting, or advising new entities. The demands of new programs and practices may leave some new entrants with questions that GCMs are uniquely positioned to answer.

Holistic Approach. The new system embodies a global, whole-person approach that represents a sea-change for health care delivery in our nation. Each of the new programs described above is designed to promote interaction and integration of providers, many of whom have not worked together in this manner before. By design, GCMs employ a global perspective. GCMs open doors, talk to everyone in the health delivery chain, and refuse to see barriers between the clinical and non-clinical sides of patient care. The GCM philosophy meshes with the ACA's coordinated care provisions in a unique way.

Changing Field. Increased consumer demand and interest at the federal level in the wake of the ACA is driving interest in the general care management field. Opportunities to perform care coordination abound. Many of the new programs discussed above create new roles and functions that either did not exist before or did not have a specific name or clearly defined role. As a result, there

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is more competition to fulfill GCM roles than in prior years. Inevitably, new programs increase demand and GCMs have more new colleagues and competitors where just a few years ago there were few.

Ownership. Unlike most providers, GCMs are not defined by their provider type. This can contribute to successful coordination, as GCMs are not easily categorized or placed into preconceived roles. GCMs are social workers, nurses, gerontologists, and other related human service professionals. This virtue can pose risks, however, because without a clearly established provider identity, a GCM might find it harder to establish authority within a team or find a place at the decision-making table when discussing a patient's care.

Federal Program Participation. Some of the new ACA programs require providers to participate in Medicare or Medicaid or otherwise function in a way that many GCMs currently do not. Those who do not participate in federal programs may find health systems difficult or almost impossible to penetrate. For many GCMs, this could pose a barrier to entry into the "new" health system. With so many different and diverse care coordination programs in existence, it is too early to predict where federal involvement will evolve in the future. However, whether this results in Medicare reimbursement for a new benefit as part of the permanent program and/or delivery system change that results less directly in the same approach, Medicare will presumably look very different in five to ten years around the issue of care management.

Conclusion

This is a time of great change in the coordinated care field, posing both opportunities and risks for GCMs, who should be open to new

roles and opportunities to "sit at the table" of patient care, even if they may not be participating providers. Networking, relationship-building, joining task forces, having a voice through education efforts and, most of all, remaining flexible are critical qualities to GCM success as the field undergoes rapid change. GCMs are well positioned to be leaders in delivery system reform and to further their unique philosophy and practice as the ACA is implemented over the next few years.

References

- Berwick, Donald M. "Strengthening Medicare and Medicaid: Taking Steps to Modernize America's Health Care System." Testimony before the Senate Finance Committee (2010) 6 – 10.
- Crippen, Dan L. "Disease Management in Medicare: Data Analysis and Benefit Design Issues." Congressional Budget Office (CBO) Report (2002) 4- 9.
- In Person Assistance in the Health Insurance Market. Available at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html>. (2013).
- Issue Brief. "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination and Value Based Payment." Congressional Budget Office (CBO) (2012) 2 – 8.
- Lind, Keith D. "Recent Medicare Initiatives to Improve Care Coordination and Transitional Care for Chronic Conditions." AARP Public Policy Institute Fact Sheet (March 2013). Washington, DC: AARP.
- Medicaid Health Homes. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html>. (2013).
- Medicaid Money Follows the Person. Available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html> (2013).
- Medicare ACO Model Summaries. Available at <http://innovation.cms.gov/initiatives/ACO/>. (2013).
- Medicare Community-Based Care Transition Program Site Summaries. Available at <http://innovation.cms.gov/initiatives/CCTP/CCTP-Site-Summaries.html>. (2013).

Medicare Community-Based Care Transition Program Solicitation for Applications (CCTP SFA). Available at <http://innovation.cms.gov/initiatives/CCTP/>. (2013).

Medicare Health Care Innovation Awards. Available at <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/>. (2013)

Medicare Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents. Available at <http://innovation.cms.gov/initiatives/rahnfr/>. (2013)

NAPGCM "What You Need To Know: What is Professional Geriatric Care Management" Available at <http://www.caremanager.org>. (2013).

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).

Where Innovation is Happening at CMMI. Available at <http://innovation.cms.gov/initiatives/map/index.html>. (2013)

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A CLASS Act—Development until the Aftermath of its Demise

Regina M. Curran, MA, CMC

Geriatric care managers work with clients who are facing the challenges of aging. For each client, the geriatric care manager develops an individualized care plan which considers the client's abilities, lifestyle preferences, and financial resources. The care plan must recognize that as time passes, the client's needs will change—and include steps which can be adapted for these changes—i.e., it must include long-term care planning.

Medicare is a health insurance program but not a long-term care insurance program. It has never covered long-term care expenses. Before Medicare existed, many older Americans were unable to obtain insurance to cover their healthcare expenses. Medicare addressed this problem. Now many older Americans are challenged by the cost of long-term care expenses.

Background – Historical Perspective

In 1965, President Johnson signed PL 89-97 which established Medicare to provide health insurance for those who were 65 or older and Medicaid to provide health insurance for those with very low income and assets. About half of these seniors had no health insurance before Medicare became available (on July 1, 1966) and many were living in poverty. Government sponsored health insurance for seniors

Medicare is a health insurance program but not a long-term care insurance program. It has never covered long-term care expenses. Before Medicare existed, many older Americans were unable to obtain insurance to cover their healthcare expenses. Medicare addressed this problem. Now many older Americans are challenged by the cost of long-term care expenses.

was first proposed in 1945. It took 20 years for legislation to be enacted. In 1972, Medicare coverage was expanded to include those entitled to Social Security disability benefits and to those with End-Stage Renal Disease (PL 92-603). There is a 24-month waiting period following a disability diagnosis before Social Security disability beneficiaries can qualify for Medicare.

The first significant change to Medicare was the Medicare Catastrophic Coverage Act of 1988 (PL 100-360). This legislation expanded Medicare coverage, added coverage for prescription drugs, and capped out-of-pocket expenses for Medicare beneficiaries. Although these were significant improvements for Medicare beneficiaries, the beneficiaries themselves rebelled when they realized that would need to pay higher premiums to cover the cost of these improvements. The voices of those who did not want to pay higher premiums were heard throughout the halls of Congress. PL 100-360 was repealed by PL 101-234 in 1989.

Medicaid covers the long-term

care expenses for those who live in an institutional setting (e.g., a skilled nursing facility) and who meet strict income/asset limitations. Medicaid is jointly funded by the federal government and by state governments. Beginning in 1981, states were allowed to

apply to the Health Care Financing Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS), for a “1915c waiver” which would “waive” the requirement that Medicaid only pay for long-term care expenses for those living in an institutional setting. By filing a 1915c waiver application, states have to establish that it would be less costly for Medicaid to provide these services in a “home- and community-based” setting rather than in an institutional setting. Each waiver application must define the conditions for participation and the number of participants. Many of the states who were granted these waivers soon had long waiting lists of potential participants.

Private long-term care (LTC) insurance policies exist. They have never been universally popular. The premiums can be significant if the policy is not purchased when the insured individual is young, healthy, and unlikely to need long-term care services for a long time. Most policies require medical underwriting, and those who might qualify for benefits earlier than others may be excluded

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from coverage. Many younger people chose not to invest in these LTC policies because they had different priorities for their spending. The lack of a significant pool of policy holders has made this type of insurance less appealing for insurance companies.

The need for a government-sponsored funding source (other than Medicaid which was taxing both federal and state budgets) to cover long-term care expenses was becoming increasingly obvious. On November 2, 2005, Senators Kennedy and DeWine introduced S-1951, the Community Living Assistance Services and Supports (CLASS) Act.

The purpose of the CLASS Act was:

- To provide individuals with functional limitations with tools that will allow them to maintain their independence and live in the community through a new financing strategy for community living assistance services and supports.
- To establish an infrastructure that will help address America's community living assistance services and support needs.
- To alleviate burdens on family caregivers.

Participation in the CLASS Act was to be voluntary. The CLASS Act would be financed by monthly premiums (through payroll deductions) for those who are working. The proposed initial monthly premium would be \$30. Employers would enroll their employees and give them the opportunity to "opt-out" of participating in the program. Alternative enrollment procedures would be available for those whose employers did not participate in the automatic enrollment or who were self-employed. A person would be eligible to receive CLASS Act benefits if he/she paid premiums for at least 60 months. During this five-year vesting period, the enrollee would have been required to work for at least three years (i.e., have earned at least four quarters of Social Security cover-

age during each of those three years). Premiums would have to be paid after the worker stops working. If the worker failed to pay the premiums, the coverage for CLASS Act benefits ends. Disabled workers would not be excluded from participating in the CLASS Act. They would pay premiums and could collect benefits after they were enrolled in the CLASS Act for five years.

When the CLASS Act was initially introduced, Tier I benefits (initially proposed to be \$50 per day) would be paid to those who were unable to perform at least two activities of daily living (ADLs) (eating, toileting, transferring, bathing, dressing, and continence) or who require supervision, cueing, or hands-on assistance to perform at least two activities of daily living. Tier II benefits (initially proposed to be \$100 per day) would be paid to those who were unable to perform or need assistance with at least four ADLs. When a person was determined to be eligible to receive benefits, that individual would receive a daily cash benefit. This daily cash benefit could be used to purchase nonmedical services and supports that the beneficiary needed to maintain his or her independence at home or in another residential setting in the community. For example, this benefit could cover the cost of home modifications, adaptive technology, accessible transportation, homemaker services, respite care, personal assistance services, and home care aides. The CLASS Act beneficiary would decide how the benefits were to be spent. Benefits would continue until the beneficiary no longer met the eligibility criteria.

Medicaid long-term care beneficiaries would also have been eligible to receive CLASS Act benefits. Institutionalized beneficiaries could have kept five percent of the daily benefit in addition to their current "personal needs allowance." The other 95 percent would be used toward their institutional care. Medicaid would have become the secondary payer after the CLASS Act payment. Individuals receiving services under a Medicaid

1915c waiver can keep 50 percent of the CLASS Act daily benefit. The other 50 percent must be used to cover some of the services received under the Medicaid 1915c waiver. The CLASS Act would have reduced Medicaid spending. Some of the costs covered by Medicaid would be paid from the CLASS Act benefits.

The CLASS Act benefits could have supplemented benefits from private long-term care insurance policies as well. Potentially private long-term care insurance policies would have "wrapped around" the CLASS Act benefit and provided better coverage for the insureds.

Legislation that is bipartisan and bicameral has the best chance of succeeding. When introduced in the Senate for the 109th Congress, the CLASS Act was a bipartisan bill. However, during the 109th Congress, the CLASS Act was not introduced in the House. When the 109th Congress adjourned, Senator Harkin was the only cosponsor added to S-1951. On July 10, 2007, Senators Kennedy, Dodd, and Harkin introduced the CLASS Act as S-1758 in the 110th Congress without bipartisan support. Three Democratic Senators¹ were the only cosponsors of S-1758 during the 110th Congress. On July 11, 2007, the CLASS Act was introduced by Representatives Pallone and Dingell as HR-3001 in the House. During the 110th Congress, eighteen Democratic cosponsors² were added to HR-3001. No action was taken on either S-1758 or HR-3001 during the 110th Congress. On March 25, 2009, Senators Kennedy, Dodd, Casey, Harkin, and Whitehouse introduced the CLASS Act in the 111th Congress as S-697. Only one Democratic Senator³ was added as a cosponsor during the 111th Congress. On March 26, 2009, Representatives Pallone, Dingell, and Kennedy introduced the CLASS Act in the House as HR-1721. Twenty-four Democratic⁴ and one Republican⁵ cosponsors added to HR-1721 during the 111th Congress. The provisions of S-697 and HR 1721 were included as Title VIII of PL 111-148 when it was enacted in

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March 2010. A fourth purpose—“to address institutional bias by providing mechanism that supports personal choice and independence to live in the community”—was added when this legislation was enacted. The CLASS Act did not receive much attention when it was introduced in Congress. It never received any Committee action. Many speculate that one reason it was included in PL 111-148 was as a tribute to Senator Kennedy who died on August 25, 2009, seven months before the legislation was enacted.

As soon as PL 111-148 (Patient Protection and Affordable Care Act—ACA) was enacted, efforts began to repeal it—either completely or by repealing specific sections so that it would be hard to implement the program successfully. There were also legal challenges to several parts of the ACA. In June 2012, the Supreme Court ruled that most of the significant parts of the ACA were constitutional. There were no legal challenges raised specifically for the CLASS Act section of the ACA. However, there were several legislative attempts undertaken in the 111th Congress and in the 112th Congress to repeal the CLASS Act.

The main objection to the CLASS Act was that it could become another underfunded federal entitlement program. Programs comparable to the CLASS Act exist in Germany, Japan, and the Netherlands. However, in these countries, enrollment is mandatory—not voluntary. Enrollment in the CLASS Act would be voluntary. There was no model to predict the number of people who would enroll. There was a concern that if the only enrollees were those who were already disabled or those who had a high likelihood of being disabled in the future, the CLASS Act could not be financially viable.

The enacted legislation required the Secretary of Health and Human Services (HHS) to develop at least

three plans for implementation of the CLASS Act. Each of the plans should ensure that the program would be actuarially sound for 75 years. Premiums would be established based on these plans. There would be between two and six levels of available benefits with the average benefit being no less than \$50 per day. Developing the plans was challenging because there were no models to use as a basis.

In October 2011, HHS Secretary Kathleen Sebelius notified Congress that HHS could not develop a statistically valid model to comply with the requirement that the program be financially sound for 75 years. Thus, HHS suspended implementation of the CLASS Act. Although the CLASS Act was then on life-support, the American Taxpayer Relief Act of 2012 (PL 112-240) signed the death certificate.

Current Perspective

This newest legislation (PL 112-240) attempted to address the issue of long-term care needs by creating a “Commission on Long Term Care” (section 643 of the Act). This Commission was to include 15 members (The President, the Speaker of the House, the Minority Leader in the House, the Majority Leader in the Senate, and the Minority Leader in the Senate. Each would appoint three Commissioners.) The legislation required that the Commissioners be appointed within 30 days after enactment of PL 112-240. This requirement was not met. The last three Commissioners were appointed on March 13, 2013.

The task of the Commission is to “develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such services and supports, including elderly individuals, individuals with substantial cognitive or functional limitations, other individuals who require assistance to perform activities of daily living, and individuals desiring to plan for future long-term care needs.”

Bruce Chernof (president and CEO of the SCAN Foundation), chairs the Commission. Mark Warshawsky (a pension expert who directs retirement research at the benefits firm Towers Watson and was a senior Treasury Department official for 2004-2006) is the Vice-Chair⁶.

PL 112-240 states that “not longer than 6 months after the appointment of the members of the Commission, the Commission shall vote a comprehensive and detailed report” which “contains any recommendations or proposals for legislative or administrative action as the Commission deems appropriate, including proposed legislative language to carry out the recommendations or proposals. A majority of Commission members must support the proposed legislation.”

If the Commission created a bill which included its recommendations, this bill would have been introduced in the Senate and in the House on the next legislative day when these chambers are in session.

On September 12, 2013, nine of the 15 Commissioners voted to put forward a report containing recommendations. There was bipartisan support for these recommendations. The Commission report did not contain specific recommendations for legislative consideration.

Among the recommendations are:

- Provide services in the least restrictive setting
- Establish a single point of contact for these services on the care team
- Use a person/family centered approach to integrate services
- Use technology effectively
- Create livable communities
- Design a simple, standard assessment mechanism to be used in all settings
- Expand “No Wrong Door”
- Provide information and assistance to consumers/family caregivers in advance of time of transition between settings

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- Advocate for public funding on the basis of service rather than setting
- Encourage caregiver interventions including respite
- Revise scope of practice to broaden opportunities for professional and direct care workers with demonstrated competency
- National criminal background checks for all long-term-care workers
- Create career ladder for direct care workers
- Integrate direct care workers in the care team
- Encourage states to improve standards and establish a certification process for home-care workers
- Create a demonstration project for Medicaid coverage for disabled workers while they are employed
- Eliminate three night hospital stay for Medicare coverage at a skilled nursing facility
- Reconsider “homebound” requirement for Medicare home health services
- Allow individuals/families with significant disabilities to access educational savings programs to assist with current or future care needs
- Create a national advisory committee to consider Commission’s recommendations and recommend funding frameworks

The challenge of financing long-term care did not disappear when the CLASS Act was repealed. The Long-Term Care Commission could not recommend a specific pathway to address this challenge. The demand for long-term care services is going to increase significantly as the “baby boomer” generation approaches the age when its members will need long-term care services and support.

It took 20 years for this country to acknowledge the fact that a health care program (Medicare) was needed. Another 20 years passed before leg-

islation was enacted to significantly change Medicare and those changes were repealed before they were implemented. Some coverages, specifically Medicare prescription drug coverage—i.e., “Medicare Part D,” but not all, of the Medicare changes proposed in PL 100-360 were enacted in 2003 as part of PL 108-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Other changes enacted in PL 100-360—e.g., a cap on “out of pocket” expenses for Medicare beneficiaries—are not available for Medicare beneficiaries in 2013. Eight years have passed since the CLASS Act was first introduced. We can’t afford to wait another 12 years before we address the need for government sponsored long-term care financing. Congressional legislators will only tackle this issue if there is significant pressure by constituents for a program similar to the CLASS Act. Constituents tend to think they are never going to need long term care—thus they do not raise this topic with their Congressional legislators.

Geriatric care managers could have benefited significantly if the CLASS Act was implemented. Potential clients could have used these benefits to pay for services recommended and monitored by geriatric care managers. Potential clients could have used their benefits to pay for the services of a geriatric care manager. Geriatric care managers should be leaders in an effort to pressure Congressional legislators to enact legislation which would fill the void left by the repeal of the CLASS Act.

Additional Information

<http://thomas.loc.gov> (information on all public laws and bills introduced in the 93rd and subsequent Congresses.)

http://www.socialsecurity.gov/OP_Home/comp2/F089-097.html (information on PL 89-97, 79 Stat.286, Social Security Amendments of 1965)

http://www.socialsecurity.gov/OP_Home/comp2/F092-603.html (information on PL 92-603, 86 Stat 1329, Social Security Amendments of 1972)

<http://www.LTCcommission.senate.gov> (information on the Commission on Long Term Care)

Endnotes

- 1 Senators Whitehouse, Obama and Clinton
- 2 Representatives Boucher, Carson, Conyers, DeLauro, Fattah, Filner, Frank, Green, Hastings, Kaptur, Kennedy, Loeb sack, Nadler, Pastor, Rothman, Solis, Space, Van Hollen
- 3 Senator Gillibrand
- 4 Representatives Bishop, Carnahan, Carson, DeGette, Doyle, Filner, Frank, Hare, Holt, Jackson, Kildee, Kilroy, Lewis, Loeb sack, McCollum, Nadler, Rothman, Ryan, Sarbanes, Schakowsky, Sires, Slaughter, Tonko, Tsongas
- 5 Representative LaTourette
- 6 The other commissioners are: Javaid Anwar, CEO of Quality Care Consultants, LLC; Judy Brachman, Chair, Jewish Federation of North America’s Aging and Family Caregiving Committee; Laphonza Butler, President SEIU ULTCW; Henry Claypool, Executive VP of American Association of People with Disabilities; Judy Feder, Institute Fellow at the urban Institute; Stephen Guillard, CEO and President of Belmont Nursing Center Corp.; Julian Harris, Massachusetts Medicaid Director; Chris Jacobs, Senior Policy Analyst at the Heritage Foundation; Neil Pruitt, Chairman and CEO of UHS-Pruitt Organization; Carol Raphael, Vice Chairman of the Board of AARP; Judy Stein, Executive Director of the Center for Medicare Advocacy; Grace Marie Turner, President of the Galen Institute; George Vradenburg, Chairman and Co-founder of USAgainstAlzheimer’s.

Regina Curran has been a geriatric care manager in the Baltimore area for 17 years. She has represented NAPGCM at the Leadership Council of Aging Organizations, a coalition of over 60 nonprofit organizations with interest in public policy issues related to aging, since 2000. She was an adjunct professor at the Notre Dame of Maryland University from 2004 until 2007 teaching public policy in the graduate gerontology program.

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The Affordable Care Act: Shaking Up the System Provides Opportunities for Care Management

Michael Newell, RN, MSN

The Patient Protection and Affordable Care Act is a complex but sweeping piece of legislation aimed at reengineering the health financing of the American Health Care System so as to improve the quality and lower the cost. The ACA, along with mandated changes in the use of technology prescribed by the HITECH Act,¹ also ushers in new challenges and opportunities for those who practice care management.

The national discussion now occurring as provisions of the ACA become reality is also sparked by such facts as:

- An estimated 32 million new people will have access to healthcare services starting in 2014 that did not have such access before.²
- With new influx of patients and not enough primary care providers (PCP), many people will have difficulty getting an appointment with their own PCP. In Massachusetts, this has led to Urgi-Centers or walk-in clinics to fill the gaps for non-emergency care. These clinics are usually placed on major highways near light industry and/or restaurants and use physician extenders such

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as Physician Assistants and Nurse Practitioner who can do diagnosis and drug prescriptions, simple x-rays, and suturing. They do not take Medicaid, but specialize in those with commercial health insurance, workers' compensation insurance, and cash for such services as school/team physicals, drug screening, etc.³

- The advent of Electronic Health Records (EHR), including an individual person keeping their own Personal Health Record (PHR), along with the "Meaningful Use" provisions of the HITECH Act on EHRs. Part of the meaningful use criteria includes improved documentation

presented to patients as they leave after the office visit. This documentation specifies the reason the patient presented themselves, the diagnosis, the plan of care, referrals, prescriptions, etc. that will assist patients and families to coordinate their own care.

- The support of "Patient-Centered Care." The Institute of Medicine (IOM) defines patient-centered care as "care that is respectful of and responsive to individual patient preferences, needs, and values" and that ensures "that patient values guide all clinical decisions."⁴

Features of the ACA supporting care management services in principle include a renewed focus on chronic care management. This includes coordination of care and health advocacy for individuals as well as "population health."

- **Care innovations** such as Accountable Care Organizations (ACOs) are expected to use a variety of methods motivated by a split of any savings that accrue from improvements in health delivery with Medicare. Since these entities have no outreach ability in the community, Care Managers who are knowledgeable about the service area are in an ideal situation to assist these organizations.

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- **Enhanced Primary Care** or the “Medical Home” model has already demonstrated significant savings, partially due to improved care coordination.⁵ Again, these organizations will need care coordination in the community to assist them in managing those high-risk individuals with three or more chronic conditions.
- **Bundled Payments.** In order to achieve meaningful savings in the inpatient setting, the Center for Medicare & Medicaid Innovation (CMMI) has introduced bundled payments,⁶ as a model for hospital payment and delivery reform. A bundled payment is a fixed payment for a comprehensive set of hospital and/or post-acute services, including services associated with readmissions. Moving from individual payments for different services to a bundled payment for a set of services across providers and care settings encourages integration and coordination of care that should raise care quality and reduce readmissions. Variants on bundled payments are being demonstrated and differ in the scope of services included in the bundle and whether payment is retrospective—based on shared Medicare savings—or prospective. This may intensify the financial risk and return to investing in changes to the efficiency and quality of care. Currently, 467 health care organizations across 46 states are engaged in the bundled payment initiative.
- **Community-based Care Transitions Program (CCTP),** created by Section 3026 of the Affordable Care Act. This

program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The 112 participating organizations are paid an all-inclusive care management fee per eligible discharge that is based on the cost of providing care to the patient and implementing the systemic reforms at the hospital level⁷.

- **Federally Qualified Health Centers (FQHCs)** that provide Primary Care in a clinic setting with extensive use of “physician extenders.” Nurse Practitioners and Physician Assistants are expected to perform care coordination activities for their constituents, including health coaching, wellness activities, and community outreach⁸. These centers have been in existence for many years, and have focused on geographic areas such as inner city or the rural poor, those with Medicaid or those lacking any health coverage at all.
- Additional incentives are intended to support the coordination of primary care, mental health, and addiction services.⁹ The goal is enhanced community-based service options for individuals with a mental health and/or substance use conditions. Medicaid state plan changes and demonstration grants are already expanding these services for individuals who have long-term care needs (e.g., dual-eligible, high-risk Medicare beneficiaries, Money Follows the Person and other Medicaid Waiver changes that will evolve based on state applications). In addition, the CLASS Act (Community Living Assistance Services and Supports Act) creates a self-funding initiative for individuals who need home- and community-based services.

The Opportunities for Care Managers

The opportunities for Care Managers will vary according to how the ACA plays out in each state and locality. Questions for Care Managers to ask themselves to assess readiness to address these opportunities include:

What payment model does the Care Manager/Care Management entity use?

- The private pay model may be enhanced due to increased awareness of the complexity of the health system and the need for coordinated care. The ability to understand coordination of benefits rules and familiarity working with diagnosis codes, CPT codes, and appeal processes will be helpful.
- Those who are conversant with the local social service system and have the ability to communicate in languages other than English will have a competitive advantage if they can convince local providers of their worth. As new innovations take hold (e.g., ACOs or bundled payment models that prospectively provide per-member-per-month payments to provider organizations to care for high-risk or high-utilizer subsets of patients) there is an opportunity for Care Managers to be paid by the organization rather than the insurance company or by private pay. The requisite expertise will be the ability to navigate the various local systems: health care, social service, surrogate courts (i.e., dealing with lost capacity and guardianship), church groups, and volunteer organizations that may assist in optimizing the health and functioning of those who have traditionally fallen through the cracks on the social safety net.

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Does the Care Manager have current knowledge and working relationships with the types of health providers that can assist managing those with chronic illness?

- Relationships with hospital discharge planners and social workers, sub-acute providers, adult day-care providers, home health and therapy providers, etc. are essential elements that most medical providers and acute care hospitals do not have, and will need if they intend to be successful managing those with chronic illness.

Can the Care Manager act in a consulting function to assist hospitals, ACOs, FQHCs and other provider organizations to manage their high risk chronically ill patients in the community?

- Those who have special expertise with classes of clients such as Alzheimer's, brain injury, cancer, diabetes, chronic heart disease, psychiatric illness, and substance abuse will be in a position to impact the care of high-risk patients.

Is the Care Manager willing to invest in new technology and learn new skills to keep up with Electronic Health Records and the new standards of documentation mandated by the meaningful use^{10,11} expectations of the HITECH Act?

- At a minimum, the Care Manager will need to be conversant with the conventions of using Microsoft Word and Outlook, navigating the web and using email and texting. The use of smartphone technology, including the applications available (e.g.,

researching drugs and their side-effects, tracking appointments, tracking productivity for billing) will be essential in the present and near future.

Endnotes

- 1 <http://www.healthit.gov/policy-researchers-implementers/hitech-act-0>
- 2 Health Reform's Next Challenge: Who Will Care For The Newly Insured? <http://www.amednews.com/article/20100412/profession/304129957/1/>
- 3 <http://www.ucaoa.org/docs/WhitePaperTheCaseforUrgentCare.pdf>
- 4 Michael J. Barry, M.D., and Susan Edgman-Levitan, P.A. (2012) Shared Decision Making — The Pinnacle of Patient-Centered Care. <http://www.nejm.org/doi/full/10.1056/NEJMp1109283>
- 5 Michael L. Paustian, Jeffrey A. Alexander, Darline K. El Reda, Chris G. Wise, Lee A. Green, and Michael D. Fetters (2013) Partial and Incremental PCMH Practice: Transformation: Implications for Quality and Costs Health Services Research. Published online on 5 JUL 2013. DOI: 10.1111/1475-6773.12085
- 6 Centers for Medicare & Medicaid Services. Bundled Payments for Care Improvement Initiative. <http://innovation.cms.gov/initiatives/bundled-payments/>
- 7 <http://innovation.cms.gov/initiatives/CCTP/index.html>
- 8 <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>
- 9 http://www.samhsa.gov/samhsaNewsletter/Volume_18_Number_3/AffordableHealthCareAct.aspx
- 10 Blumenthal, D., Tavenner, M. (2010). The "Meaningful Use" Regulation for Electronic Health Records. *The New England Journal of Medicine*, 363, 501-504.
- 11 Halamka, John D. (2009). Making Smart Investments in Health Information Technology: Core Principles. *Health Affairs*. 385-289. DOI: 10.1377/hlthaff.28.2.w385

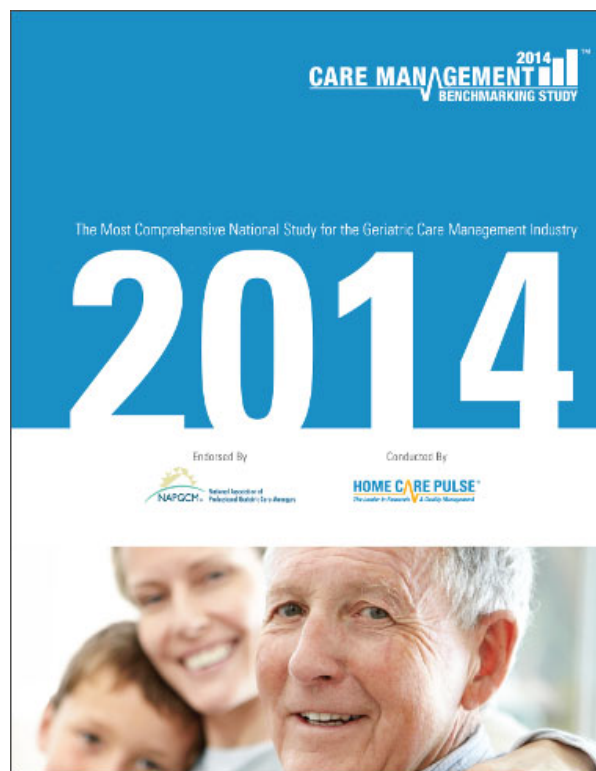
Michael Newell, RN, MSN, CCM is founder president of LifeSpan Care Management LLC, Haddonfield, N.J. Michael is the author of two nursing texts: Using Nursing Case Management to Improve Health Outcomes and Reinventing Your Nursing Career. He is also an adjunct clinical instructor for the nursing program at Thomas Jefferson University and lectures widely on topics of medical case management.

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The Affordable Care Act and Its Impact on Care Management

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Executive Summary

The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, mandates widespread coverage of health benefits. Many recognize that to meet the cost of universal coverage, the most expensive, most complex care must be better managed. There is growing recognition that the baby boomer generation will exponentially affect the cost of long-term care as a result of increasing longevity and incidents of complex chronic care. While this phenomenon is not new, it is being newly examined due to concerns about shifting demographics, the growing cost of health care, and consumer perceptions.

There is broad understanding that people with chronic disease face a greater risk of having deficits in instrumental activities of daily living (IADL) and activities of daily living (ADL). In recent years, numerous studies have linked high rates of hospitalization and emergency room visits among seniors to complex chronic conditions and functional limitations.

In fact, according to a LewinGroup analysis of medical expenditures published in 2010, seniors with multiple chronic conditions who received help with IADL and ADL deficits were seven times more likely to be among the top five percent of the costliest patients to treat as defined by total-medical-claims expense in the prior 12-month period — more than twice the rate of those with multiple chronic conditions alone.

Chan et al. reported in the Archives of Physical Medicine and

There is broad understanding that people with chronic disease face a greater risk of having deficits in instrumental activities of daily living (IADL) and activities of daily living (ADL). In recent years, numerous studies have linked high rates of hospitalization and emergency room visits among seniors to complex chronic conditions and functional limitations.

Rehabilitation that the cost increases are attributed to greater frequency of care events (e.g., hospital admissions, outpatient visits) rather than an increase in the intensity of those events.¹

Rehospitalizations are of particular concern. According to recent research published in the New England Journal of Medicine, one in five seniors are rehospitalized within 30 days of being discharged from a hospital,² fueling the reality that Medicare beneficiaries account for 15 percent of the US population³ but more than two-thirds (37 percent) of hospitalizations and almost

half (47 percent) of total hospital costs.⁴ But are these seniors really sicker? Alarming, only half recall receiving self-care instruction⁵ or seeing a doctor after discharge,⁶ suggesting that a substantial number of rehospitalizations could be prevented.

This article discusses the opportunities for and threats to geriatric care management practice as a result of care utilization, recent health legislation, and industry trends in response to these changes.

Background

SeniorBridge is a national care-management company with a 13-year heritage of managing the care of people with complex chronic conditions in their homes. These clients spend between \$1,000 and \$6,000 per month because they cannot manage their own care.

The company's interdisciplinary approach utilizes an integrated care-management team of nurses and social workers to address functional, environmental, behavioral, and medical needs. SeniorBridge's proprietary web-based electronic health-record platform documents data about clients' medical, behavioral, and functional health; environment; social supports; and financial and legal status. Assessments from multiple providers include medical diagnoses, history of treatments, and hospitalizations. The breadth of this medical record enables SeniorBridge's care managers to monitor and address the full array of issues as they affect clients' chronic care needs and preferences. Furthermore, the

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electronic health record facilitates real-time communication between care managers and health-care providers to assure that the services in the home are consistent with the physician-driven plan of care. In this manner, the care manager becomes the physician extender in the home setting while assuring maximum use of primary care to forestall preventable use of emergency room visits and hospitalizations. Importantly, the data can also be used to track trends in hospitalizations, diagnoses, challenges, and successful interventions.

In 2010, when health-care reform legislation was first discussed as a viable option, SeniorBridge's data showed that clients receiving the firm's integrated care had 90 percent fewer emergency room admissions, 80 percent fewer hospitalizations, and 70 percent fewer 30-day rehospitalizations compared with national data. These clients were, on average, age 80 and older, had multiple chronic illnesses, five deficits of activities of daily living (ADLs) or Independent Activities of Daily Living (IADLs), and frequently had limited family and social support or other psychosocial factors that placed them at the highest risk for hospitalization and costly care.

Recognizing the incentives and penalties set out by the Affordable Care Act, SeniorBridge approached health plans, hospital groups, and provider groups with the opportunity to capitalize on SeniorBridge's model. SeniorBridge's approach had demonstrated improved health outcomes and patient satisfaction while reducing health-care costs among frail individuals who were likely to need the most costly care.

SeniorBridge invested in several pilot studies that produced promising results. In one study of individuals who were among a physician group's top five percent most chronically ill and costly to treat as defined by

total-medical-claims expense in the prior 12-month period, SeniorBridge reduced hospital admissions by 70 percent — meaning two in three high-cost hospitalizations were averted; a 54 percent reduction in total emergency room visits; and a 48 percent savings in health-care costs.⁷

In addition to these utilization and financial results, a satisfaction survey of the customers enrolled in the program indicated that 100 percent of those who responded strongly agreed that the care management program met their expectations, and 85 percent said they strongly agree that the program also improved their experience with their physician.

The outcomes helped to define successful care management approaches for patients with complex medical conditions and functional limitations and to fundamentally change how care is provided to the frailest seniors in our health system. The results also opened the door to scale the model to more individuals.

In July 2012, Humana, a national health company, acquired SeniorBridge and merged it with its telephonic care management organization, Humana Cares, in order to improve health outcomes and cost efficiencies among frail members and tasked a combined team of Humana Cares / SeniorBridge care managers to support 200,000 individuals.

It enabled SeniorBridge's private-pay clients to benefit from Humana's vision, robust health programs, and technology. The move also provided best-practice insights for the care management industry into how to capitalize on and prepare for opportunities and threats associated with the Affordable Care Act. Most importantly, it validated the field of care management and expanded its reach to those who cannot afford to pay privately. In fact, Humana Cares/ SeniorBridge care management programs are at the forefront of Humana's ongoing business strategy given its success in improving the health of its members while reducing overall health-care costs.

A Brief History of Care Management

The birth of care management can be traced to two distinct beginnings. One was a response to pressures to control costs of health care for hospitals, providers, insurance companies, and other health industry companies. We usually think of this category as "case management." This model is grounded in the need to manage health utilization costs. Positive outcomes of case management are financial: "I paid X to the nurse case manager, and it reduced the cost of care by X dollars."

The second beginning was driven by consumer demand for support and advocacy to cope with illness, caregiver stress, and increased out-of-pocket cost to the individual. This demand was, in part, stimulated by a health-care policy shift that determined payment for hospitalizations by Diagnostic Related Groupings (DRG). This policy shift, in turn, shortened the time patients could remain in the hospital and left consumers with more responsibility for managing their own care. Positive outcomes of care management included client satisfaction measured in a fee-for-service environment by client retention and word-of-mouth referrals.

Over the last two decades, in the face of an aging demographic, increasing medical costs, and the demand for more universal health coverage, Centers for Medicare & Medicaid Services (CMS) started issuing requests for proposals (RFPs) for demonstration projects to test and measure the impact of these models.

The Congressional Budget Office (CBO) reviewed the independently evaluated outcomes of ten major demonstrations. The evaluations showed that most demonstration projects have not reduced Medicare spending. Programs in which care managers had substantial direct interaction with physicians and significant in-person interaction with patients were more likely to reduce Medicare spending than other

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programs, but on average even those programs did not achieve enough savings to offset their fees.

Results from demonstrations of value-based payment systems were mixed. In one of the four demonstrations examined, Medicare made bundled payments that covered all hospital and physician services for heart bypass surgeries; Medicare’s spending for those services was reduced by about ten percent under the demonstration. Other demonstrations of value-based payment appear to have produced little or no savings for Medicare.

Unlike these demonstration programs that produced successful health outcomes but failed in their return on investment and ability to become self-sustaining, SeniorBridge and Humana have produced an evidence-based program that demonstrates a sustainable business model that facilitates good social policy without additional investment of public funds.

“With our program, we’re able to reach people who ordinarily wouldn’t be able to access care managers. We’re able to make an impact on a whole new population,” explained Mary Wegman, RN, CCM, GCM of the Humana Cares / SeniorBridge care management network.

These data are a turning point for

the industry and demonstrate that care management is a proven model for health organizations to capitalize on Affordable Care Act incentives and penalties for improving outcomes, reducing overall health-care costs, and improving consumer satisfaction.

Key Learnings – Message to Care Managers

I. Data: The Opportunity

To attract industry partnerships, we must be more data-driven about care-management outcomes. Beyond client satisfaction, we must be able measure what we do and its attributable health outcome in order to

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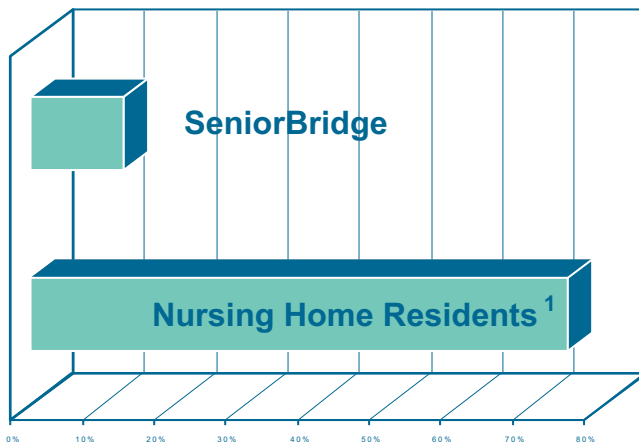


FIGURE 1

SeniorBridge Clients Have 80% Fewer Falls¹ than Nursing Home Residents

¹ Rubenstein LZ, et al. Falls in the nursing home. *Annals of Internal Medicine* 1994;121:442-51.

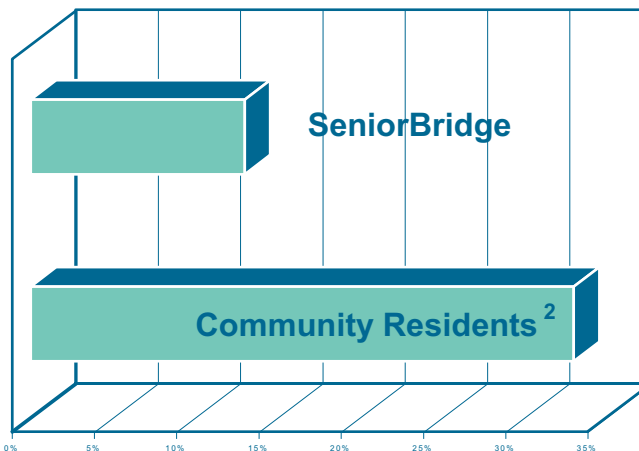


FIGURE 2

SeniorBridge Clients Have 60% Fewer Falls² than Community Residents

² Hausdorff JM, et al. Gait variability and fall risk in community-living older adults: a 1-year prospective study. *Archives of Physical Medicine and Rehabilitation* 2001;82:1050

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persuade industries to invest in our interventions.

Industry partnerships are an opportunity for all care managers — both as an immediate revenue stream and as a validation of the care-management model that will stimulate greater acceptance of the cost of care management in relationship to the value.

If insurance companies, hospitals, and doctors pay for care management, families will also want to pay for it — so long as they can compare it with a standard of practice. Private care managers will then need to produce metrics to help families make informed choices.

Challenges of Not Having Data

Data is essential to understanding trends in your customer base, your successful interventions, and your return on investment. Often we make assumptions about what is successful without fully understanding the outcomes of our efforts.

At SeniorBridge, even as we collected data, we weren't always looking at trends. In 2008, we believed a large number of clients — at least 30 percent — were struggling with psychiatric illness. But once we collected data on diagnoses over time, we learned that in fact only ten to 12 percent had a primary psychiatric diagnosis. These data influenced not just our marketing efforts but also our training and our long-term strategic planning.

Care-management companies who don't document incidents lack access to trends in falls, bed sores, ADL, cognitive impairment, and hospitalizations, as opposed to merely monitoring nursing home admissions.

At SeniorBridge, we were able to show fall rates were significantly less than for clients of other home-

care-only companies; less than the general population at same-age grouping who are not receiving home care; and dramatically less than same-age groupings of nursing-home residents. (See figures 1 and 2.)

Clearly, care managers need to invest in information technology and understand outcome research. Small care-management businesses, unfortunately, have limited resources to invest. As an industry, we have an opportunity to work together to spearhead an initiative to standardize key metrics and consolidate data for the profession through professional organizations, such as the National Association of Professional Geriatric Care Managers (NAPGCM) and the Case Management Society of America (CMSA).

II. The 80-20 Rule – Identifying Where Care Management Can Be Most Effective

Recognizing that the Affordable Care Act puts added pressure on health organizations to reduce overall health costs, care managers now have more incentive to develop interventions and best practices that improve health outcomes, member satisfaction, and cost efficiencies among individuals with the most complex needs.

It is recognized that a large majority of resources are used on a small fraction of individuals. Industry data demonstrate that 16 percent of Medicare members account for 63 percent of costs.⁸ Among Humana members, 20 percent of care recipients drive 75 percent of cost.⁹

Together with Humana, the SeniorBridge leadership team evaluated data and best practices to develop core programs that would address the needs of the 20 percent of Humana members who account for 75 percent of health-care costs by providing one-on-one coaching tailored to member needs.

By understanding the commonalities among this population, we were able to develop predictive models to anticipate needs, intervene as appropriate, and avert adverse

events. Hospitalizations and emergency room visits are a failure of our health-care system to provide needed support, and we needed to identify individuals who would benefit from care management early in the process.

“As a result of Humana's predictive models, we're having an opportunity to intervene earlier in the progression of disease and functional decline than we were able to with private pay clients who often come to us after a crises,” said Humana Cares / SeniorBridge's Wegman. “That's substantial because we can truly focus on empowering and on preserving independence.”

Interventions need to be tailored to members' individual needs based on their functional limitations and disease severity through telephone calls, video, and in-home visits. These measures can be augmented with technology interventions, including biometric monitoring, motion sensors, and interactive voice response.

III. The 30-Day Readmission Problem

To respond to incentives and penalties set out by ACA legislation, special programs need to address the 30-days-after-hospital and sub-acute discharge, when seniors are most vulnerable for a readmission.

These transition programs differ from transition services provided in a fee-for-service world, where length of service is tailored to meet individual needs and resources. Rather, a limited amount of time to support these patients means care managers need to provide a systematic, strategic approach that is highly personalized. In 30 days, care managers must rank and triage problems to provide support that is scalable.

“We have to demonstrate results quickly so we have to be very focused,” continued Wegman.

IV. Engagement – A New Approach

One surprise faced by SeniorBridge care managers is the difficulty in engaging members. One might surmise that being skilled in demonstrating the value of care management to families who are willing to pay for services

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would make it simple and easy to provide a service for free. However, enrollment into these transition programs is a challenge.

Rather than interacting primarily with family caregivers, care managers in this model often involve the care recipient as the key decision-maker. Initial research demonstrated that these individuals, even when no fee is involved, were resistant to agreeing to programs they didn't understand and/or that implied they needed help.

Techniques to engage members in the care-management process are unique in the health plan universe and require an identification of care recipient influencers and unique language that will resonate.

Furthermore, the types of problems we are addressing as care managers are different.

"The care recipients I serve today are frequently more at risk for hospitalizations and complications

than private-pay clients because they lack financial means to access transportation and buy things like healthy food and diabetes test strips; they face limited health literacy about their disease; and they do not have access to basic technology like a phone. These are unique problems that as care managers we must cultivate expertise," Gregg A. Billeter, RN, BSN, CCM, GCN

V. Regulation and Simplicity: Tensions Affecting Patient Satisfaction

In the private-pay world, we often describe the care recipient (the older person) as the client. But in fact, we work with a system of support including family caregivers, doctors, lawyers, and other supports. When working with a highly regulated Medicare environment, the exchange of information that is so important in integrating care and empowering family caregivers may be more challenging because of privacy regulations.

Consent forms and other regulatory requirements may be

confusing or intimidating, and these challenges can lessen engagement and reduce efficiencies. Care managers need to both learn the restrictions and be creative in overcoming these hurdles.

"We have streamlined processes that allow us to be more efficient, but we also are faced with restrictions on how we can interact with members and what resources we can utilize," continued Wegman.

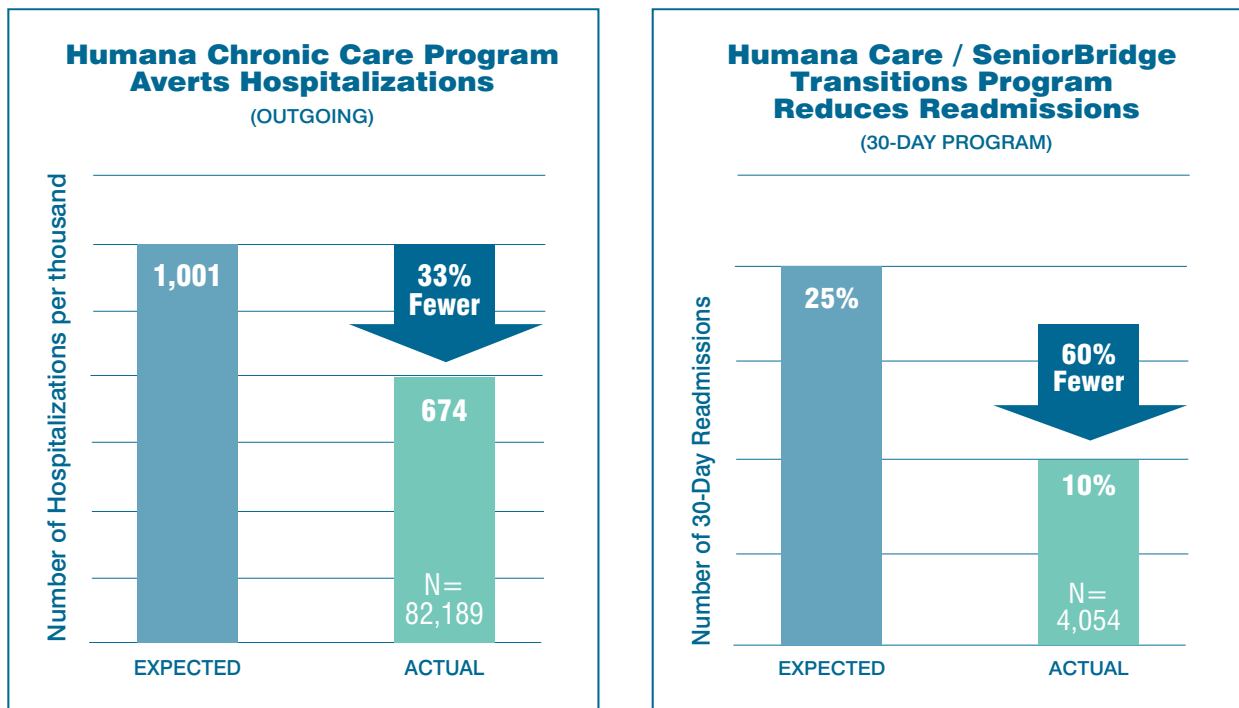
VI. Implications of Mistakes

Scalability of processes and quality control are paramount. Unlike the private-pay world, where a mistake generally results in a lost client, working in highly regulated industries poses greater risks: one mistake can jeopardize a contract — or thousands of clients.

In reaction to health reform, care managers need to have consistent, measurable processes that will track processes and demonstrate positive outcomes.

Initial outcomes from the Humana
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FIGURE 3



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Cares / SeniorBridge Transitions program show more than 33 percent reduced hospitalizations among the 20 percent most high-risk individuals and 60 percent reduced hospital readmissions. (See Figure 3.)

Summary

The Affordable Care Act provides payments, incentives, and penalties for successful outcomes and moves away from simply paying for interventions. Care management is a proven process for improving outcomes, cost efficiencies, and consumer satisfaction – all of which are at the heart of the Affordable Care Act. Health organizations will no doubt continue to look to care management as a solution.

Considering the prevalence of chronic conditions and functional limitations among our elderly, it is no surprise that Medicare beneficiaries 65 years and older account for 12 percent of the U.S. population but more than one-third of hospitalizations and almost half of total hospital costs. Emergency room visits and hospital admissions are failures of the healthcare system to provide timely, effective care.

The problem stems from our healthcare system's focus on disease management and a lack of attention to the reality that activity limitation is an independent risk factor for increased health-care costs.

It is now recognized that when patients with complicated medical, functional, and cognitive conditions receive care coordination in the home by specially trained geriatric care managers, hospitalizations and emergency room admissions are substantially reduced.

As an industry, we must identify patients with these functional limitations as being at risk of rehospitalizations. We must ensure that such patients have the proper support system that goes beyond medical needs to address physical

and cognitive function that puts them at risk for adverse events. Does the patient have food in the refrigerator to ensure adequate nutrition and hydration? Is the patient taking medications or vitamins you don't know about? Are there support limitations preventing the patient from complying with a discharge plan?

We must do this in an efficient and scalable way. And we must prioritize to meet the needs of the care recipient and the system. Finally, we must do this with the same consumer-centric principles on which care management in the private world was founded.

Endnotes

- 1 LewinGroup® analysis of 2006 Medical Expenditures Panel Survey, 2010
- 2 Jencks, *New England Journal of Medicine*, 2009
- 3 "The Medicare Beneficiary Population Fact Sheet", AARP, 2007 http://assets.aarp.org/rgcenter/health/fs149_medicare.pdf
- 4 "Medicare Hospital Stays: Comparisons between the Fee-for-Service Plan and Alternative Plans: Statistics Brief #66," Healthcare Cost and Utilization Project <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb66.jsp>
- 5 Flacker, *J Hospital Medicine*, 2007
- 6 Jencks, *N Engl J Med*, 2009
- 7 "Two in Three Hospital Admissions Averted and Care Costs in Half in a One-Year Study of High-Risk Medicare Members Enrolled in Metropolitan's Medical Home Model of Care with SeniorBridge Care Management" (June 2012) Metcare and SeniorBridge Websites http://finance.boston.com/boston/news/read/21604819/two_in_three_hospital_admissions_averted_and_care_costs_cut_in_half_in_a_one
- 8 Chronic Conditions Among Medicare Beneficiaries (CMS) 2012 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>
- 9 Humana Data 2012

Claudia Fine, LCSW, MPH, CMC, CCM

Chief of Professional Services

Claudia Fine spearheads clinical training and communications at the combined Humana Cares / SeniorBridge organization. A pioneer in the field of geriatric care management she has served in industry and community leadership roles throughout her 30-year career in elder care including as one of the first presidents of the National Association of Professional Geriatric Care Managers.

Eric C. Rackow, MD

President of Humana Cares / SeniorBridge

Eric C. Rackow, MD, heads SeniorBridge and Humana Cares as an integrated organization and is responsible for the growth and continuing success of the division. Additionally, Dr. Rackow serves as a Professor of Medicine at the New York University School of Medicine. Prior, Dr. Rackow had numerous roles in hospitals in the greater New York area, including president of NYU Hospitals Center.

Beware of What You Wish for OR The Affordable Care Act and Me

Phyllis Mensh Brostoff, CISW, ACSW, CMC

"To follow what's happening with the new health care law right now, you have to understand that for all the deep divisions on the issue, there's actually a real bipartisan consensus about how the American health care system ought to be reformed. Or rather, there are two of them — a dishonest consensus among politicians and an honest consensus among people who study public policy for a living. ...Obamacare has an unwieldy, Frankenstein's monster quality in part because the law is trying to serve both consensus-es at once... the White House's decision [to suspend the employer mandate] is a step toward honesty in policy-making. It takes us a little closer to a world where politicians of both parties actually level with the public, and acknowledge that employer-provided health insurance is an idea whose time has passed."

Oh, how fervently I wished for everyone in the US to have health insurance but not through their employer! I wanted Medicare for all – a national system already in place, paid for through payroll taxes, very efficient

administratively (five percent overhead) and competing for business with the private system. That was my ideal scenario, but that was not to be. The only thing that could be wrestled through the Congress in 2010 was the Affordable Care Act. As it begins to go from the paper it was written on into implementation, it turns out it may not be very affordable. If most of a company's employees are

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comparatively low wage earners and it is a "large" employer (defined as having more than 50 FTE employees), it may cost more than anticipated.

Our company, Stowell & Associates, started in 1983 providing only care management services to elderly and disabled adults. In 1985 one of our clients needed a special type of caregiver. We could not find a caregiver with these special skills among the existing home care agencies in our community. Our client, H, was chronically mentally ill, 55 years old, and desperately wanted to live on her own in a condo she owned. She had no friends and very little in the way of homemaking skills or experience. So we made

the decision to go into "home care" and hired our first caregiver, Sherry, to work with H. To this day Sherry still works for the company. Over the years she has asked for a variety of benefits, i.e., training as a certified nurse's aide, in-service training opportunities to keep up her certification, health insurance, paid leave, and a 401-k. Over the years the company has added these benefits

for our other full-time employees (those who work at least 30 hours a week). In 1988 the company joined the local Chamber of Commerce to access a chamber-sponsored health insurance plan, and after a few years, consolidated our insurance business through an insurance broker for all our insurance needs.

The company began expanding and growing in the 1990s.

Currently we have about 150 caregivers, eight care managers, an executive director, a clinical director, schedulers, recruiters, and an accounting department. Combined staff are about 175, more than half of them working a minimum of 30 hours a week or more. This number of employees puts us squarely into the category of a large employer (50 or more FTE employees) that must provide affordable health insurance to our employees. In the past when reviewing our agency profile, we had little bargaining power and were considered a "bad" group from an underwriting point of view: too many woman (99 percent), too old

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Beware of What You Wish for OR The Affordable Care Act and Me

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(average age 50) and too low income (averaging close to \$13 per hour for our caregivers). This was a concern as we moved into understanding the regulations within the Affordable Care Act.

Based on medical underwriting standards and age tiers, the average cost per employee for a single plan had been about \$820 per month. Only one-third (33%) of our eligible employees (full time, defined by working on the average 30 hours or more per week) actually enroll in the company's health insurance. Eighteen percent (18%) have other insurance. Twenty-one percent (21%) have government insurance, i.e., Medicare. Fifteen percent (15%) have no insurance coverage at this time because it is unaffordable for them. There are thirteen percent (13%) whose reasons for not having the company plan are unknown. The company currently pays sixty percent (60%) of the plan cost. On average an employee in the company-sponsored health plan pays \$328 per month for individual coverage. Unfortunately those employees making approximately \$13 per hour cannot afford the cost and remain uninsured— and it is two times the amount that is defined as “affordable” under the Affordable Care Act for a caregiver working an average of 30 hours a week (\$20,000 per year).

According to the ACA and the way the math works, no plan can cost more than \$1,900, or \$158 a month, for our lowest paid full-time caregiver to be considered affordable by the ACA (9.5 percent of their gross wage). And to make matters worse for these hourly paid employees, Wisconsin's governor refused the Federal extended Medicaid benefit for single adults which would cover those with incomes up to 130 percent of poverty. However, Wisconsin will have a federal health insurance exchange because the governor refused to set up a state-run exchange.

From an administrative point of view, I want all of our employees to have health insurance. Office employees who have access to primary care can obtain preventative care. Caregivers can get help with health issues that might save them from work injuries. We have offered this benefit for more than 20 years, and it only seems fair that everyone have health insurance. Our client fees have reflected the ongoing insurance cost to us, so we do not anticipate increasing our fees.

There is a requirement within the Affordable Care Act (ACA) that has potential for affecting our company and employees. One interesting outcome of the ACA's requirement for community rating (i.e., underwriting can't be based on your group's health histories, just age, size of family, smoker/not, and location) is that our insurance premium may actually be reduced in 2014. Based on the demographics of our workforce, we have already been paying a higher rate for years. Employers having this number of employees or more with a lot of young workers are likely to be stuck with a large increase of premiums since premiums for younger workers may rise. This is not relevant to us.

Now that the employer mandate is suspended for a year, we won't be penalized if the cost is not “affordable.” However, the cost of

this insurance may still be too much for our lower wage employees. Our plan is that we'll probably add a second choice that will meet the “affordability” rule. We will not know what the 2014 rates will be until November of this year.

Most members of NAPGCM will not be in the position our agency is in because they are considered small employers. If they are not offering health insurance now, they and their employees can use the Marketplace (formerly called an “Exchange”) to find insurance. It is designed to be an on-line tool that will look like the Medicare Plan Advisor or Expedia. Since all employees will, in theory anyway, be required to have health insurance, it would seem that all businesses will adjust fees to manage this expense. But, everything is still up in the air. Personally I think it will take at least five years before the ACA will be fully implemented and fully integrated into the fabric of the country. To repeat myself, I would have preferred just paying a payroll tax and including everyone in Medicare (or a Medicare-like system), but they didn't listen to me!

Reference

A Hidden Consensus on Health Care, by Ross Douthat, New York Times, July 6, 2013 <http://www.nytimes.com/2013/07/07/opinion/sunday/douthat-a-hidden-consensus-on-health-care.html?ref=rossdouthat#comments>

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Beware of What You Wish for OR The Affordable Care Act and Me

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Affordable Care Act (ACA) Overview

Purpose of Affordable Care Act (ACA): increasing access to health insurance so that, in theory, everyone has access to affordable health care.

Consumer Protections in ACA: Prohibition against pre-existing conditions limiting access to insurance, continuation of coverage of adult children to 26, guaranteed issuance, subsidies for individuals between 100 percent - 400 percent of Federal poverty level, no more than 90-day waiting period before obtaining coverage.

Definitions

Employer Mandate:

“Applicable large employer” is defined as having employed 50 or more individuals who worked on the average 30 hours or more a week in the prior calendar year.

Individual Mandates: All individuals are to have health insurance or face tax penalties.

Full-Time Employee: Works on the average 30 hours or more a week for employer

Marketplace/Exchange:

Entity set up to allow the public to compare health care insurance options electronically, run by individual states, or the Federal government if a state refuses.

Coverage Options:

- Platinum: designed to pay 90 percent of covered claims costs.
- Gold: designed to pay 80 percent of covered claims costs.

- Silver: designed to pay 70 percent of covered claims costs.
- Bronze: designed to pay 60 percent of covered claims costs.

Individual Subsidies: Available to individuals with income up to 400 percent of Federal poverty level without access to affordable employer sponsored coverage. Individual applies for health insurance coverage through an Exchange/Marketplace and it will certify if individual is eligible for subsidy.

Affordable Employer Sponsored Coverage: Cost of employee only coverage to the employee can be no more than 9.5 percent of their income.

Penalties: There are employer penalties if the employer does not offer minimum essential coverage to all FTE employees and at least one employee receives a subsidy through an Exchange/Marketplace but this was suspended until 2015. There are employee penalties if they do not get health insurance (\$95 per adult and \$47.50 per child, up to \$285 per family, or 1 percent of family income in 2014; \$325 per adult, \$162.50 per child up to \$975 per family or 2 percent of family income in 2015; \$696 per adult and \$347.50 per child up to \$2,085 per family or 2.5 percent of family income in 2016).

Minimum Essential Coverage

(MEC): Coverage has to include 10 essential health benefits; ambulatory/outpatient, emergency, hospitalization, maternity and newborn care, mental health and substance use, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness

services and chronic disease management, pediatric services including pediatric dental and vision care.

Minimum Value (MV):

Employee plan must have actuarial value of at least 60 percent.
<https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-10463.pdf>

References

All definitions and information above from Antonie(TJ) Goedheer, Consultant, Employee Benefits, Diversified Insurance Services, 100 N. Corporate Drive, Suite 100, Brookfield, WI 53045 agoedheer@div-ins.com.

See Henry J. Kaiser Foundation website for a tool that calculates “affordability” based on employee’s wages: www.kff.org/interactive/subsidy-calculator

Phyllis Mensh Brostoff, CISW, ACSW, CMC is the CEO and co-founder of Stowell Associates, providing geriatric care management and care managed home care services to the elderly, disabled adults and their families since 1983.

Phyllis is a founding member of the National Association of Professional Geriatric Care Managers and was the President of the National Board in 2009 and President of the Midwest Chapter Board 2006-2008.

Understanding National Health Reform: Why Big Data isn't Enough

LESSONS FROM MASSACHUSETTS HEALTH REFORM

*Natasha Dolgin, MD/PhD Candidate
and Kate Lapane PhD*

The authors gratefully acknowledge our colleagues Jay Himmelstein, for reviewing an earlier version of this paper and providing insight and expertise, and Gillian Griffith for her help in reviewing the final draft.

Introduction

The National Health Reform bill signed in March 2010, known as the Affordable Care Act (ACA), was designed based on the Massachusetts Health Reform bill signed by Governor Mitt Romney in 2006 (Chapter 58). The frameworks for MA and National Health Reform share core similarities such as the creation of Marketplaces¹ (The Massachusetts Health Connector), expansion of Medicaid (MassHealth), tax subsidies for working low-income families, and the concept of “shared responsibility” between government, employers, and individuals.

While the frameworks for the two bills are similar, the economic and political environments in which they were passed could not be more different. Years of incremental changes preceded the official signing of Chapter 58 in Massachusetts and its signing predated the economic crash of 2008. The bill had been generally well received by the public, whereas political strife characterizes National Health Reform, with Republicans now pursuing their 41st vote against “Obamacare” as of September 2013 (Whitaker). In this era of instability and uncertainty, the public will want to see results... and fast.

As the primary body responsible for implementing National Health Reform, the federal Centers for Medicaid and Medicare Services (CMS) will depend on standardized systems for measuring the progress of its state subsidiaries in meeting the goals of Health Reform. State accountability to CMS may involve measuring and reporting up to 1,000 process and outcomes metrics in the future (Kaiser 2011). States are undergoing massive systems overhauls in order to modernize their processes and informatics systems. Based on Massachusetts' experience with Health Reform, Health and Human Services (HHS) named Massachusetts one of 7 “early innovator” states, and provided funding for these states to help lead the way in National Health Reform (HHS 2011).

The paper seeks to describe both the benefits of CMS reporting requirements as well as their limitations in being able to provide meaningful public health data, such as data on healthcare access and health outcomes. CMS reporting requirements are powerful in that they establish the precedent and infrastructure for outcomes measurement. However, even with a seemingly infinite pool of standardized CMS outcomes measures, every stakeholder in National Health Reform (federal government, state governments, vendors, the public, etc.) will have a different agenda as far as what defines “successful” Health Reform, and to address these

differing priorities, leaders will need to take outcomes measurement beyond what is required by CMS. As such, it is important for the public health community to take an active role in defining and measuring public health outcomes of interest to the relatively silent but ultimately most important stakeholders in Health Reform, the general public.

Section 1: Modernizing Informatics Systems & Processes

The national healthcare paradigm is undergoing dramatic transformations through the new role of government in the health insurance market. An overwhelming magnitude of systems change is happening almost simultaneously. At the same time as marketplaces are being launched at both the Federal and State levels, state Medicaid systems are expanding, and eligibility and enrollment (E&E) processes, previously run independently by states' Medicaid programs, are being integrated with federal data systems through a new “Federal Data Services Hub,” created and operated by CMS. There will also be various levels of integration between E&E processes within states' Medicaid and Marketplace systems. This new integrated system is designed to promote efficiency in E&E processes, but it also serves an important purpose for CMS: the ability to monitor systems and reduce system abuses through the validation

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Understanding National Health Reform: Why Big Data isn't Enough

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of personal information with federal data sources, such as the IRS for example.

The new “Hub” is a revolution in decades-old insurance E&E processes. States are in the process of either completely replacing or updating their Medicaid informatics systems in order to be compatible with the new streamlined process. The new informatics systems are a prerequisite for states to operate the new programs being implemented under reform, and those working in the healthcare field are all too familiar with the challenges of transitioning from outdated paper-based systems to electronic systems (Electronic Medical Records). In summary, CMS is responsible for immense program implementation and management that the agency is approaching very systematically, with diligent progress measurement along the way.

Section 2: CMS—Agency Operations Measurement

CMS Outcomes Measurement

As part of its approach to managing the massive, multi-level system change effectively, CMS will be holding states accountable for reporting progress in implementing the new E&E processes. With so many different models of health reform across states (some with State-Based Marketplaces while most have Federally Facilitated Marketplaces, some expanding Medicaid others are not), standardized process and outcomes measurement will allow states to share a common denominator in the path toward successfully implementing Healthcare Reform. The reports will help CMS to identify states and processes that need support, as well as highlight state models that are successful so that other states may benefit from the knowledge as well. Mandating states to create the infrastructure, and precedent, for measuring their processes will also be

invaluable to states internally, as it will empower them to identify areas that need improvement and have a means for continuous evaluation of targeted interventions.

The new “Hub” is a revolution in decades-old insurance E&E processes. States are in the process of either completely replacing or updating their Medicaid informatics systems in order to be compatible with the new streamlined process.

CMS Measurement Agencies

CMS will be tracking Medicaid and SBM process outcomes through aggregate data submission by respective agencies. Reporting metrics include agency efficiency at processing applications, call center volumes, and volume of consumer complaints. State Medicaid systems will be required to report on such metrics to CMS on a monthly basis (weekly during open enrollment during Fall 2013).

While CMS will be able to directly monitor the processes of the Federally Facilitated Marketplace (FFM) that it itself will be operating, states that have state-based marketplaces (SBMs) will be required to report on metrics along the same lines with what is required of Medicaid systems. The differences will lie in the specific metrics required, timing of reporting (quarterly) and the agency responsible for collecting and

analyzing this data: the new Consumer Information and Insurance Oversight (CCIIO) division of CMS created by ACA will be in charge of State-Based Marketplace oversight. Based on the experience with the Massachusetts Health Connector, private vendors that are working with SBMs today (such as Xerox, IBM, Deloitte) may expect and conduct more sophisticated business and “big data” market analytics than CCIIO requirements for data reporting. These additional mechanisms for state-centric outcomes measurement will enable states to refine their business models to suit the needs of their own population.

However, while CMS requirements will capture data on Medicaid and Marketplace operations and vendors may capture additional data on insurance market dynamics overall, none of the planned reporting requirements alone or in combination will sufficiently address the implications of health reform on public health issues of health care access and outcomes. Analyzing the implications of health reform from a public health perspective will best be served by pooling data from many different sources including both publicly and privately derived data.

Section 3: The Intersection of Government and Insurance Data Interests

“Big” Utilization Data

The new paradigm of government collaboration with the health insurance industry creates new avenues for big data analysis surrounding issues of healthcare utilization, outcomes, and costs. Research has shown that healthcare utilization increases when individuals acquire health insurance (Anderson et al 2012). At the same time as national implementation of insurance reform, many states are turning away from fee-for-service healthcare models in favor of adopting Managed Care models that aim to incentivize better health outcomes and drive costs down. Managed care

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models facilitate the evaluation of healthcare utilization, outcomes, and costs on a population health level because the claims data collected covers a wide range of health services that patients utilize, from hospital admissions to community care providers. In this way, utilization data is sometimes used as a proxy to understand the more complicated outcome to measure directly, health quality, and utilization data is also a keystone for analyzing costs to the healthcare system overall. In Massachusetts and many other states, an All Payers Claims Database (APCD) is one avenue through which population-level health activity and outcomes can be evaluated. In addition to APCDs, there are national databases that collect data on health utilization and trends through the American Healthcare Quality and Research division of Health and Human Services (AHRQ), which hosts the Health Care Utilization Project (HCUP) for example.

In Massachusetts, the APCD is managed by what was formerly known as the "Division of Health Policy and Finance." However, and perhaps signifying the potential power of such a database for understanding state trends, this center was re-mastered to become what is now the "Center for Health Information and Analysis," fondly referred to as CHIA (mass.gov 2012). CHIA was created in November 2012, when a new wave of Health Reform that focuses on cost containment and quality was signed (Chapter 224). Prior to the creation of CHIA, Massachusetts did not have a designated center for measuring, analyzing, and producing timely reports on Massachusetts Health Reform.

CHIA is designed as a center for collecting data and reports from different sources reporting on MA Health Reform to paint a greater overall picture of outcomes than what APCD can offer alone. Relying on claims data to understand public

health provides a limited perspective, in that these databases only provide transactional data, and only include those that are insured and actively using the healthcare system. Granted, as we work toward achieving universal coverage, these databases will grow in value. However, there are other domains important to public health beyond transactional encounter data, such as understanding where patients are having difficulty with scheduling or accessing healthcare since reform, patients' own perceptions of their health quality or quality of life, and the effect of policies on availability and utilization of free care services.

The MHRS proved to be an incredible resource for understanding Massachusetts Health Reform. At the same time, there is still much work to be done on understanding the impact of Reform on health outcomes in MA, a more complex and challenging outcome to measure.

Explaining "Big" Utilization Data

In Massachusetts, data on the impacts of Reform on health were contributed by many independent sources, ranging from national and state surveys to universities and private sector research. In addition to existing surveys such as the National Health Interview Survey (NHIS), Blue Cross Blue Shield Foundation created the Massachusetts Health Reform Survey (MHRS) in 2006 (BCBS Foundation 2011). This survey was specifically designed to measure

the unique issues pertaining to health reform. For example, while the aforementioned HCUP surveys could provide data on overall Emergency Department utilization across states, the MHRS was able to provide data from the patient perspective, addressing issues pertaining to the health needs of the population, and it shed light on identifying the reasons underlying the utilization trends observed in large databases. For example, it asked whether the respondent did not receive needed medical treatment or preventative care in the last year, and whether they attributed any of their unmet medical needs to the costs of healthcare. These sample outcomes showed significant improvement over the course of MA Health Reform, particularly for the lower socioeconomic demographic (Long et al 2013). The MHRS proved to be an incredible resource for understanding Massachusetts Health Reform. At the same time, there is still much work to be done on understanding the impact of Reform on health outcomes in MA, a more complex and challenging outcome to measure.

Section 4. The Importance of including Public Health Stakeholders in the Health Reform Conversation

The general public is the ultimate stakeholder in Health Reform, both as investors and as those that are ultimately impacted by Reform. However, unlike the implementers of health reform such as CMS, the public cannot design and implement reporting requirements that enforce government accountability for measuring public health outcomes in the way CMS is holding states accountable for implementing reform. Incorporating the priorities of long-term public health interests into the baseline measurement of reform today is particularly challenging as states scramble to rise to the challenge of basic process reporting required by CMS and vendors. Despite this,

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it is important that those affected by Reform have a voice, whether through states' Departments of Public Health (DPH), patient advocacy groups, public health researchers, or otherwise.

Despite the reality that Departments of Public Health play a crucial role in implementing Health Reform through the administration of public services, they are not implicitly included or funded as part of CMS plans for measuring Health Reform. Health Reform in Massachusetts was primarily designed through conversations between policy makers and insurance companies, while the Department of Public Health did not get a seat at the table until much of the plan was already in place (Auerbach 2013). In transitioning to an insurance-based system, public services in Massachusetts saw dramatic shifts in free care and "safety net" utilization and funding (Nardin, Auerbach). Auerbach reflects that in retrospect, had the Department of Public Health established a strategy for program evaluation from the beginning (perhaps he would say in a similar manner to CMS strategy in National Health Reform now), it could have adjusted much more quickly and appropriately to these shifts. Instead, the voice of our Department of Public Health was often reactive rather than anticipatory.

Auerbach describes one example where the Department of Public Health played a crucial role in bringing public health priorities to the forefront for policy makers: when the state decided to cut \$52m in funding for childhood immunization programs. This shifted the cost and administrative burden to providers so suddenly, that the state was at

risk for having a shortage crisis. The DPH was successfully able to form a coalition and campaign for a solution, to which policy makers responded together with insurance companies to create a system in which insurance companies contributed to a state fund for childhood immunizations. While this is an example of a reactive measure taken by DPH in response to a sudden change, it is an example that shows the key role that public health stakeholders have in advocating for the public need throughout health reform.

We will all be eager to see outcomes as soon as possible, but reality is that with such immense program transformation, we may not have access to reliable data in the earliest phases of implementation.

Conclusion

The nation will be watching what happens with National Health Reform with great anticipation and for many, apprehension. We will all be eager to see outcomes as soon as possible, but reality is that with such immense program transformation, we may not have access to reliable data in the earliest phases of implementation. In addition, based on the Massachusetts experience, early data may be misrepresentative of the overall direction of Health Reform, as trends take time to stabilize.

On the other hand, it is important to begin tracking valuable data on healthcare access and outcomes issues early in order to compare later data to state baselines. Measuring healthcare quality is difficult due to nebulous definitions, challenging measurement mechanisms, and the time it takes for downstream consequences of an intervention to be revealed. Partnerships between policy

makers and Departments of Public Health, universities, patient advocacy organizations and think tanks will be important for implementing and measuring the goals of National Health Reform. For example, in 2012, the Massachusetts Department of Public Health created a Statewide Quality Advisory Committee administered in collaboration with CHIA, in an effort to help define and support research in healthcare outcomes and quality.

In summary, this paper recommends public patience and caution in interpreting early data in health reform, and to avoid overestimating the value of "big data." It advocates for strategic and quality data collection and analysis that will be able to address the implications of health reform, beyond the measurement of its short-term implementation processes.

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cho-social, and economical forces which impact disease production. She has made a wide range of reports and oral presentations and has publications and citations in a number of highly-ranked multidisciplinary, biomedical and clinical peer-reviewed journals, mainly in the field of geriatric pharmacoepidemiology.

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Interests include: quality improvement and outcomes measurement, bioethics, and health policy.

Resources

(in order of appearance)

Whitaker, Morgan. "For 41st Time, GOP votes against Obamacare." MSNBC 12 Sept 2013. NBCNews.com. Web. 14 Sept 2013.

States Leading the Way on Implementation: HHS Awards "Early Innovator" Grants to Seven States. Health and Human Services News Release. February 16, 2011. <http://www.hhs.gov/news/press/2011pres/02/20110216a.html>

Performance Measurement Under Health Reform: Proposed Measures For Eligibility and Enrollment Systems and Key Issues and Trade-offs to Consider. Kaiser Foundation December 01 2011.

The Health Connector. Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2012. December 2012.

Anderson M, Dobkin C, Gross T. The Effect of Health Insurance Coverage on the Use of Medical Services. American Economic Journal: Economic Policy, American Economic Association, vol. 4(1), pages 1-27, February 2012.

Commonwealth of Massachusetts. Division of Health Care Finance and Policy. Important Information about the Division of Health Care Finance and Policy and the Center for Health Information and Analysis. November 2, 2012. Web. 17 Sept 2013.

Lessons from the Implementation of Massachusetts Health Reform. BCBS Foundation. March 2011.

Long SK, Stockley K, Nordahl KW. Coverage, access, and affordability under health reform: learning from the Massachusetts model. Inquiry. 2012-2013 Winter;49(4):303-16.

Auerbach J. Lessons from the front line: the Massachusetts experience of the

role of public health in health care reform. J Public Health Manag Pract. 2013 Sep-Oct;19(5):488-91.

Dr. Rachel Nardin, Dr. David Himmelstein, Dr. Steffie Woolhandler. Massachusetts' Plan: A Failed Model for Health Care Reform. Harvard Medical School.

Hanchate AD, Lasser KE, Kapoor A, Rosen J, McCormick D, D'Amore MM, Kressin NR. Massachusetts reform and disparities in inpatient care utilization. Med Care. 2012 Jul;50(7):569-77.

Cohen RA, Ward BW, and Schiller JS. Health Insurance Coverage: Early release of estimates from the National Health Interview Survey, 2010. National Center for Health Statistics. June 2011. Available from: <http://www.cdc.gov/nchs/nhis.htm>.

Dorn S, Hill I, Hogan S. The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage. State Health Access Reform Evaluation, a national program of the Robert Wood Johnson Foundation. The Urban Institute, Washington, DC. 2009 November.

John E. McDonough, Brian Rosman, Fawn Phelps and Melissa Shannon. The Third Wave of Massachusetts Health Care Access Reform. Health Affairs, 25, no. 6 (2006): w420-w431 (published online September 14, 2006; 10.1377/hlthaff.25.w420)

Footnotes

- 1 Current nomenclature refers to exchanges as "Health Benefits Marketplaces." Other names used in the past include Health Insurance Marketplaces and Health Insurance Exchanges.

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Effects on Medicare Clients & the Affordable Care Act (ACA)

Carol S. Heape, MSW, CMC, Fellow

“The ACA’s elements were also so numerous that the media and local service network executives rarely understood what was in there. Many still don’t. As a result, most people were uncomfortable with any part of the topic, and rather than discussing it as objectively as possible, they simply said they didn’t really know.”¹

Media reports state consistently that individuals who already have health insurance will not be affected to a large degree with the implementation of the Affordable Care Act. For those on Medicare, the changes that have already begun and will continue may be subtle enough that older individuals may not sense much of a change at all. The following information may be helpful when questions arise about the effects of the ACA and Medicare:

“The ACA adds “annual wellness visits.” These include comprehensive risk assessment and a personalized prevention plan. It includes medical and family history, various biometrics such as body mass index and blood pressure, cognitive impairments, and a five to 10 year schedule of screening tests. These services will be provided by the Medicare program at no charge to the enrollee no deductibles or co-payment obligations will apply to wellness visits.”²

Bruce Chernof writes in “The Three Spheres of Aging in America: The Affordable Care Takes on Long-Term Care Reform for the 21st Century” that the ACA does extend

“The ACA directs some of its most significant financial changes at Medicare Part C, the managed care component of the Medicare program” which currently pays 14 percent more per patient than the traditional Medicare program.

the Medicare Trust Fund by 12 more years which should more than double the solvency of Medicare for the near future.

On prescription drug coverage (Medicare Part D), “the new law reduces the donut hole by decreasing an enrollee’s cost responsibility in this coverage gap from 100 percent to 25 percent over the next ten years.”³ There are increased costs for upper-income Medicare beneficiaries as the ACA increases the premium for these recipients.

“The ACA directs some of its most significant financial changes at Medicare Part C, the managed care component of the Medicare program”⁴ which currently pays 14 percent more per patient than the traditional Medicare program. Known as the Medicare Advantage programs, the ACA makes budgetary cuts to these plans which may change the benefit structure for the individual enrollee. There may be

cuts to vision and dental care within the capitated programs. Medicare Advantage programs will continue to be available but with the possibility of increased co-pays and premiums as the 14 percent payout is discontinued.

With older adults utilizing more of the healthcare system dollars, the ACA is looking at policies that reduce hospitalizations and readmissions to not only reduce Medicare costs but also to improve the quality of patient care.

“The main focus of the ACA’s nursing home initiatives is to require that additional nursing home information be included in the existing Nursing Home Compare tool on Medicare’s website. In addition, there is a requirement that criminal violations and civil penalties be publicly disclosed which may add weight to the sanctions.”⁵

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Endnotes

- 1 Browdie, R., “Health Reform, Politics, and Conflict: Is This Any Way to Serve America’s Elders?”, ASA Generations, Spring 2011, 6-10.
- 2 Kaplan, R., “Older Americans, Medicare, and the Affordable Care Act: What’s Really In It for Elders?”, ASA Generations, Spring 2011, 19-25.
- 3 Ibid.
- 4 Ibid.
- 5 Ibid.