

The Impacts of the Implementation of the *Affordable Care Act (ACA) on the Nursing Facility Industry

Presentation to the American College of
Health Care Administrators

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March 14, 2012

Also known as the PPACA – Patient
Protection and Affordable Care Act



Money Follows the Person

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- The MFP Rebalancing Demonstration Program was authorized by Congress in 2005 (Deficit Reduction Act)
- Affordable Care Act (ACA)
 - Extends the MFP Demonstration Program through September 30, 2016
 - Any unused portion of a State grant award made in 2016 would be available to the State until 2020
- With the addition of thirteen new State grantees in February 2011, 43 States and the District of Columbia are currently implementing MFP Demonstration Programs

MFP Statutory Objectives

- Increase use of home and community based, rather than institutional, services
- Eliminate barriers that restrict flexible use of Medicaid funds for HCBS
- Increase the ability of state Medicaid programs to provide HCBS to eligible persons transitioning from institutions to community settings
- Ensure adoption of procedures for quality assurance and continuous quality improvement

Two Overarching Goals

- **Increase the number and proportion of institutionalized Medicaid enrollees who can be transitioned into the community**
- **Rebalance the state's LTSS system by developing infrastructure and increasing the % of total LTSS spending for HCBS**

MFP Implementation

- **MFP helps states achieve these goals through:**
 - **Increasing enhanced FMAP rate for Medicaid HCBS**
 - **Providing Federal funding for administrative costs**

- **States are required to provide continuity of care for transitioned individuals after their MFP Demonstration period of enrollment ends**

Projected MFP Participants

Projected Participants	CY11*	CY12	CY13	CY14	CY15	CY16
Participants Each year	179	443	451	373	373	373
Cumulative Participants	179	622	1,073	1,446	1,819	2,192

*** Demonstration began July 12, 2011—Actual Participant Count through 12/31/11=52 Participants (+ 62 Enrollees)**

Qualified Individuals

An individual must:

- Be residing in a qualified inpatient facility for 90 or more consecutive days (excluding rehab days)
- Be a resident of MA
- Be MassHealth eligible and the last day has to be a Medicaid-paid inpatient day in the LTC facility
- Wish to participate in the program and sign an MFP Informed Consent
- Be transitioning to a qualified residence

Qualified Residence

- **Home/apartment owned or leased**
- **Community-based residential setting – no more than 4 individuals including**
- **Assisted Living Facilities**
 - **Must be a residence with living, sleeping, bathing and cooking areas**
 - **Unit must have lockable access and egress**
 - **Cannot require that services must be provided as a condition of tenancy**
 - **Must not require notification of absences from the residence**
 - **Aging in place must be a common practice**
 - **Leases may not reserve the right to assign or change apartments**

New MFP Waivers

- **MFP Community Living Waiver**
 - For individuals who do not need 24 hour supports or supervision
 - Allows for access to a variety of community-based waiver services that support the waiver participant to live safely in the community
- **MFP Residential Supports Waiver**
 - For individuals who require supervision and staffing hours/day, 7 days/week and receive services in a provider-operated and staffed setting
 - Residential supports include: residential habilitation in a group home serving no more than 4 individuals, assisted living services, and shared living.

Additional Information

- MFP Website:

<http://www.mass.gov/eohhs/consumer/disability-services/living-supports/community-first/money-follows-the-person-rebalancing-grant.html>

Balancing Incentive Program (BIP)

Balancing Incentive Program

- **BIP is offered to states by CMS to help states increase non-institutionally based share of LTSS expenditures. USING ACA authorized funds, states that undertake certain structural reforms can receive enhanced federal matching payments for new community LTSS spending.**
- **States must be below the 50% Institutional vs. Community Spending threshold to receive 2% FMAP.**

Balancing Incentive Program

Implementation

- States are required to make the following 3 structural changes:
 - Implement a No Wrong Door/Single Entry Point System that ensures all people receive the same information about LTSS options when they enter the system.
 - Offer conflict free case management - states must develop conflict free case management services that develop a service plan, arrange for services and supports, supports directing services and conducts ongoing monitoring to ensure people's needs are met.
 - Develop and use a core standardized assessment instrument – this determines eligibility for community based programs; and is used to develop an individual service plan to address needs.

Balancing Incentive Program

- **Approximately 84,000 MassHealth individuals are projected to inquire about LTSS.**
- **This aligns strategically with MassHealth goals and the Governor's Community First policy.**
- **MassHealth shares this goal with CMS – and aligns with strategic intent to deliver LTSS in an integrated way as part of overall package of MassHealth services.**

Duals Demonstration Project

Duals Demonstration Project: Dual Eligible Care Integration Initiative in Context of MA Health Reform

- Integrating care and financing for dual eligible adults ages 21-64 is fundamental to broader health system reform and transformation agenda
 - Restructuring how care is delivered
 - Aligning payment incentives to support better care
- Builds on foundation of initiative to develop and spread person-centered medical homes throughout the Commonwealth
- Signature component delivery system transformation and payment reform, complementing development of bundled payments, accountable care organizations, and a transition from fee-for-service provider payments to global payment methodologies

Duals Demonstration Project: Dual Eligible Care Integration Initiative in Context of MA Health Reform

- Target population: 115,000 dual eligibles ages 21-64 with full MassHealth and Medicare benefits
- Integrated Care Management
 - Medical and non-medical services provided through multi-disciplinary care teams
 - Members direct care plans and decisions
 - May include other persons chosen by the member
- Medicare Services: All Part A, Part B, and Part D services
- Medicaid State Plan Services
- Additional Behavioral Health Diversionary Services
- Additional Community Support Services, which promote independent living and help avert unnecessary medical interventions
 - Personal care assistance, home modifications, assistive technologies, peer support, respite, community Health Workers (for wellness, nutrition, chronic disease self-management, etc.)

Duals Demonstration Project: Dual Eligible Care Integration Initiative in Context of MA Health Reform

Medicare Services

Medicare primary payer for:

- **Part A Hospital Insurance:** helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice and some home health care.
- **Part B Medical Insurance:** helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.
- **Part D Prescription Drug Coverage:** helps cover prescription drugs. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium.

Duals - Covered Medicaid State Plan Services

Medicaid primary payer for:

- Adult day health services
- Adult foster care services
- Chronic disease inpatient hospital services
- Day habilitation services
- Acute treatment services for substance use disorders
- Clinically managed high intensity services for substance use disorders
- Emergency services programs
- Psychiatric day treatment
- Dental services
- Family planning services
- Hearing aid services
- Nurse midwife services
- Nursing facility services
- Orthotic services
- Personal care services
- Private duty nursing services
- Transportation services
- Vision care

- Medicaid provides coverage for many Medicare-type services after Medicare has been exhausted.

- Medicaid pays for Medicare cost sharing for certain dual eligibles.

Additional Behavioral Health Diversionary Services

- Mental health and substance use disorder diversionary services will provide clinically appropriate alternatives to inpatient services or support individuals returning to the community following an acute placement or provide intensive support to maintain functioning in the community.
- Crisis Stabilization
- Community Support Programs
- Partial Hospitalization
- Structured Outpatient Addiction Program
- Intensive Outpatient Program
- Inpatient-Outpatient Bridge Visit

Additional Community Support Services:

- Community support services will promote independent living and help avert unnecessary medical interventions, e.g., avoidable or preventable emergency department visits.
- Personal care assistance
- Home modifications
- Assistive technologies
- Peer support
- Respite
- Community Health Workers
 - Wellness
 - Nutrition
 - Chronic disease self- management

Care Coordination and Management

- Care of every enrolled member will be anchored in primary care with the competencies of a person-centered medical home (PCMH), including:
 - Multi-disciplinary, team-based care
 - Integrated behavioral health services
 - Planned visits with the care team
 - Easy and flexible access
 - Person-centeredness, including cultural competence
 - Care coordination and management
- Care Coordinator works with member and other participants the member chooses to develop care plan that address full range of member's needs

Provider Network Requirements

- Capacity to provide full continuum of covered services
- Demonstrated ability to meet the needs of persons with disabilities
- Continuity of care
- Choice of providers in proximity to a member's home
- Inclusion of members' providers that are willing to join plan network
- Continual enrollment by entities of providers that meet plan requirements
- Outreach by entities to members' preferred providers and caregivers

Beneficiary Protections

- Require entities to offer choice of providers
 - Ensure enrollee choice of PCP and access to a broad array of specialists and other support service providers
 - Outreach to members' current providers if not already in network
 - Demonstrate capacity to provide, directly or through sub-contracts, full continuum of covered services
- Ensure robust internal and external complaints, grievances and appeals processes
 - Unified set of requirements for entities' internal processes
 - Single external process that meets all regulatory requirements and ensure rights of both Medicare and Medicaid are protected
- Require entities to operate enrollee customer services
 - Accessible, toll-free telephone service; oral and TTY/comparable interpretation services available
 - Training and clear expectations for providing information

Impact on Medicare and Medicaid Costs

- Most profound impact on cost will be in the longer term, associated with helping members become and stay well
- There is also potential for savings in the short term
 - Elimination of incentives for providers to shift costs by transferring patients from one service or setting to another
 - Opportunity for MassHealth to share in acute care savings (such as decreased use of inpatient and ER) that would result from additional investments in care coordination, expanded behavioral health care and long term services and supports
 - Opportunity for savings due to decreased use of institutional care
- Detailed actuarial analysis to come following receipt of Medicare data in November

Accountable Care Organizations

About Accountable Care Organizations

- Under the proposed rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve with Original Medicare (that is, those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- **ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,**
- **Networks of individual practices of ACO professionals,**
- **Partnerships or joint ventures arrangements between hospitals and ACO professionals, or**
- **Hospitals employing ACO professionals, and**
- **Other Medicare providers and suppliers as determined by the Secretary**

Accountable Care Organizations

■ Measuring Quality Improvement

- The proposed rule links the amount of shared savings an ACO may receive to its performance on quality standards.**
- The proposed rule sets out proposed performance standards for these measures and a proposed scoring methodology, including proposals to prevent providers in ACOs from being penalized for treating patients with more complex conditions.**

Discussion/Questions