H.R. 3962, the *Affordable Health Care for America Act*: Issues Affecting Long Term Care November 3, 2009

Below is a summary of the provisions of the *Affordable Health Care for America Act* (H.R. 3962) affecting long term care, as introduced on October 29. This document is a brief summary and will continue to be refined.

The chart below displays the changes in Medicare cuts from the version of the bill as introduced on July 14, 2009, America's Affordable Health Choices Act (H.R. 3200), contrasted with the version introduced on October 29, 2009, the *Affordable Health Care for America* (H.R. 3962). The total amount of cuts has decreased $8.1 billion, from $32 billion to $23.9 billion, as reported by the Congressional Budget Office. We understand that the greatest change is in the amount of savings attributed to Section 1111, which decreased from $6 billion to $0, since that provision no longer generates savings as the FY 2010 SNF PPS Final Rule went into effect on October 1, 2009. Cuts were also decreased to a one year delay in imposing the SNF market basket productivity adjustment until fiscal year 2011, representing a victory for long term care.

Changes to LTC-Related Funding

Section	*Affordable Health Care for America* H.R. 3962* NEW BILL		*America's Affordable Health Choices Act* H.R. 3200# OLD BILL		Difference between H.R. 3200 (old) and H.R. 3962 (new)
	One Year	Ten Year	One Year	Ten Year	
Elimination of SNF Market Basket Update from 1/01/10 – 9/30/10 combined with Productivity Adjustment 2010-2019 Sections 1101 and 1103	($0.4 billion)	($23.9 billion)	($0.6 billion)	($26.0 billion)	$2.1 billion
Recalibration of SNF PPS Case Mix Indexes (Rule) Section 1111	0	0	($0.8 billion)	($6.0 billion)	$6 billion
Reduction of Potentially Preventable Hospital Readmissions	TBD	TBD	TBD	TBD	TBD
CLASS Act Section 2581	0	$72.5 billion	n/a	n/a	$72.5 billion

Source: Congressional Budget Office Cost estimate for the bill as introduced on October 29, 2009 (H.R. 3962, Affordable Health Care for America Act of 2009) October 29, 2009 http://www.cbo.gov/doc.cfm?index=10688&type=1

#***Source: Congressional Budget Office Cost estimate for the bill as introduced on July 14, 2009 (H.R. 3200, America's Affordable Health Choices Act of 2009) July 17, 2009 http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf***

Medicare

Elimination of Skilled Nursing Facility (SNF) Market Basket Update from 1/01/10 – 9/30/10 combined with Productivity Adjustment 2011-2019 (Sections 1101 and 1103)

As of January 1, 2010, the Skilled Nursing Facility (SNF) market basket update implemented on October 1, 2009 will be removed for the remainder of Fiscal Year (FY) 2010. Further, the SNF market basket index will be reduced by increases in a productivity factor beginning in FY 2011.

The estimated impact in FY 2010 is $400 million, with five year savings of $6.0 billion, and ten year savings of $23.9 billion.

Recalibration of SNF PPS Case Mix Indexes (Section 1111)

After analysis and in consultation with stakeholders, the bill would modify the SNF PPS to include a separate non-therapy ancillary services rate component. The new rate component will be implemented in a budget-neutral manner. An interim adjustment for non-therapy services will be implemented on January 1, 2010, which will increase the payment for non-therapy ancillary services by 10% and reduce the payment for therapy services by 5.5%. The bill also includes a provision for an outlier policy for non-therapy ancillary services. Funds for the outlier provision will be capped at two percent of total projected SNF PPS payments. This is derived from the June 2008 MedPAC Report to Congress proposals on reforms to the SNF PPS.

Reduction of Potentially Preventable Hospital Readmissions (Section 1151)

Creates an interim readmissions policy for post-acute providers beginning in FY 2012, and directs the Secretary to develop risk adjusted readmission rates for post-acute providers and implement a readmissions payment system for those providers similar to the hospital system on or after FY 2015. Directs the Secretary to monitor inappropriate changes in admission practices by hospitals and post-acute providers and authorizes the Secretary to penalize providers that are avoiding patients at risk of a readmission.

Post Acute Bundling Reform (Section 1152)

Directs the Secretary to submit to Congress a detailed plan on how to implement post-acute bundled payments. Contains requirements for the Secretary to consult with stakeholders and to take specific issues into consideration, including protections for consumers to preserve access to care and patient choice. It also contains requirements for data collection and analysis. The bill contains a bundling pilot project. Converts the existing Acute Care Episode demonstration project to a pilot program and expands the program so that it may include bundling of payments for hospitals and post-acute providers, effective January 1, 2011.

Therapy Caps (Section 1231)

Extends the exceptions process until the end of 2011.

Elimination of Part D cost-sharing for Certain Non-institutionalized Full-Benefit Dual Eligible Individuals (Section 1202)

Eliminates Part D cost-sharing for those dual eligible individuals receiving care under a home and community based waiver who would otherwise require institutional care in a hospital, nursing facility, or intermediate care facility for the mentally retarded. NCAL lobbied to include this provision, which would eliminate Part D cost sharing for 57% of the dual eligible population in assisted living communities (those covered under Medicaid waivers). Dual eligibles in assisted living facilities receiving Medicaid services directly under Medicaid state plans, rather than under waivers, would not be covered.

Repeal of Part D Deadlines Relating to Submission of Claims by Pharmacies Located in or Contracting with Long-term Care Facilities (Section 1183)

Eliminates deadlines for long-term care pharmacists to file Part D claims to allow more time for improved coordination with state Medicaid programs.

Part D Accurate Dispensing in Long Term Care Facilities (Section1187)

Requires Part D plans to develop utilization management techniques to reduce prescription drug waste in long-term care facilities.

Intelligent Assignment in Enrollment (Section 1205)

Gives CMS the authority to use an enrollment process for subsidy eligible individuals into Part D plans that accounts for the quality, cost and/or formulary of plans.

Ability of Physician Assistants to Certify Need for Skilled Care (Section 1114)

Allows physician assistants to order skilled nursing facility care and lists them as an eligible provider for hospice care.

Independence at Home Demonstration Program (Section 1312)

Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

Clinical Social Work Services (Section 1307)

Allows clinical social workers (CSWs) to bill separately for discretionary psychotherapy services provided to SNF patients requiring such treatment, excluding them from the existing PPS consolidated billing requirements. The exempted services are the same psychotherapeutic services provided by psychiatrists and psychologists, which already may bill independently in SNFs. Note that this provision does not apply to the mandated medical social services that SNFs provide to all patients, which are covered by the global per diem payment.

Marriage & Family Therapy and Mental Health Counselor Services (Section 1308)

Adds state-licensed or certified marriage and family therapists and mental health counselors as Medicare providers. They are to be paid at the same rate as clinical social workers under the fee schedule. These providers are also exempted from the PPS consolidated billing requirements, allowing them to bill independently for discretionary psychotherapy services rendered to SNF patients.

Health-care Acquired Conditions (Section 1751)

Prohibits federal matching payments for the cost of health care acquired conditions that are determined to be non-covered services for Medicare purposes.

Medicaid

Temporary Nursing Facility Supplemental Payment Program (Section 1745)
Establishes a temporary 4-year program of supplemental payments directly from the Centers for Medicare & Medicaid Services to dually certified nursing facilities with high percentages of Medicare and Medicaid patient days to assist them in meeting the costs of care to Medicaid beneficiaries. A total of $6 billion would be available for such payments over the period 2010 through 2013. The Medicaid and CHIP Payment Advisory Committee (MACPAC) would be required to study the adequacy of Medicaid payment rates to nursing facilities in each State and report to Congress by December 31, 2011.

Assuring adequate payment levels for services (Section 1728)

Requires State Medicaid programs to submit annually to the Secretary the payment rates to be used to reimburse providers for furnishing covered services and directs the Secretary to review such rates for sufficiency. AHCA is pleased that this section was included in the bill through the work of Rep. Chris Murphy (D-CT) on our behalf.

Report on Medicaid Payments (Section 1746)

Requires State Medicaid programs to submit annually to CMS information on the determination of rates of payment to providers for covered services. AHCA is pleased that this section was included in the bill through the work of Rep. Chris Murphy (D-CT) on our behalf.

Extension of FMAP Increase (Section 1749)

In the *American Recovery and Reinvestment Act* enacted earlier this year, Congress increased federal medical assistance percentage (FMAP) funds to states with high unemployment rates that maintain access to Medicaid services during the recession. The funding was tied to the states maintaining their effort on eligible beneficiaries. This provision extends that increase in federal Medicaid payments program for six months until 6-30-2011.

Nursing Home Transparency

Required Disclosure of Ownership and Additional Disclosable Parties (Section 1411)

SNF/NFs must disclose information on their organizational structures as well as information on officers, directors, trustees, or managing partners, including names, titles, and start date of service. Bill requires disclosure of owners of a whole or part interest in any mortgage, deed or other obligation exceeding 5 percent of a facility's total property/assets. Additional disclosable parties include entities that provide policies or procedures for any of the operations of the facility, provide financial or cash management services, or provide management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

The bill requires a facility to make all disclosable parties information available to public upon request and update the information as necessary to reflect changes. Facilities are required to certify to Secretary and IG that the information submitted upon request is "accurate and current" and the Secretary must develop a standardized format for the information within two years of date of enactment.

Compliance Program (Section 1412)

Bill requires nursing facility/skilled nursing facility have a compliance and ethics program in operation 36 months after enactment of the bill. The compliance/ethics program must be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care.

Nursing Home Compare Medicare Website (Section 1413)

Bill requires Secretary to ensure that information provided for comparison of nursing homes is posted on the Nursing Home Compare website in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable. The website must also include summary information on the number, type, severity and outcome of substantiated complaints. States must also maintain a consumer oriented website providing info on SNF/NFs in the state including State inspection reports, facilities plan of correction, and any other info that State or Secretary considers useful to the public.

Reporting of Expenditures (Section 1414)

Requires SNF/NFs to report expenditures separately for direct care services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods beginning on or after two years after the date of enactment.

Standardized Complaint Form (Section 1415)

Requires the Secretary to develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program. The bill also mandates a series of additional whistleblower protections.

Ensuring Staffing Accountability (Section 1416)

Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, including information on agency or contract staff. Effective two years after date of enactment.

Background Checks (Section 1417)

Establishes a national program for long term care facilities and providers to conduct screening and criminal and other background checks on prospective direct access patient employees.

Increased Civil Monetary Penalties (CMPs) (Section 1421)

Bill mandates that Secretary may increase CMPs where it can be established that a deficiency was a direct and proximate cause of death of a resident in a facility up to $100,000 and provides additional authority to the Secretary to raise or adjust CMPs under certain circumstances. 30 days after imposition of a civil penalty, the bill gives the facility an opportunity to participate in independent formal dispute resolution; however penalties will still be collected prior to the resolution of appeals.

National Independent Monitor Pilot Program (Section 1422)

Requires Secretary along with OIG to establish a pilot program to develop, test, and implement use of independent monitoring program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities. The bill also calls for the Comptroller General to conduct study on financial status, resident care and performance of SNFs and NFs including an examination of ownership and control interests and affiliated parties of facility.

Notification of Facility Closure (Section 1423)

Requires the administrator of a facility that is preparing to close to provide written notification to residents and other parties and to prepare a plan for closing that ensure safe transfer of residents to new facilities.

Dementia and Abuse Prevention Training (Section 1431)

Requires SNFs and NFs to conduct dementia management and abuse prevention training prior to employment and, if the Secretary determines appropriate, as part of ongoing training.

Study and Report on Training Required for Certified Nurse Aides and Supervisory Staff (Section 1432)

Requires the Secretary to study the content of training requirements for certified nurse aids and supervisory staff of SNFs/NFs and to submit a report with recommendations on content and length of training to Congress within two years of date of enactment.

Qualification of a Director of Food Services of a Skilled Nursing Facility/Nursing Facility (Section 1433)

Requires that SNF/NF full-time directors of food services shall be a Certified Dietary Manager, Dietetic Technician, or have equivalent military, academic, or other qualifications as specified by the Secretary.

Quality

Establishment of national priorities for quality improvement (Section 1441)

Directs the Secretary to establish national priorities for performance improvement, incorporating recommendations from outside entities. These priorities should reflect areas that contribute to a large burden of disease, have high potential to decrease morbidity and mortality and improve performance, address health disparities, and have the potential to produce the most rapid change based on current evidence.

Development of New Quality Measures; GAO Evaluation of Data Collection Process for Quality Measurement (Section 1442)

Based on the national priorities for performance improvement established in this part, the Secretary shall develop, test and update new patient-centered and population-based quality measures for the assessment of health care services. Provides $25 million for this section. Instructs the Government Accountability Office (GAO) to periodically evaluate the program and

determine the effectiveness of the quality measures and the extent to which these measures can result in quality improvement and cost savings, and report to Congress. (Note: This is the current National NQF national priorities partnership project and Bruce is on the steering committee)

Multi-stakeholder Pre-rulemaking Input into Selection of Quality Measures (Section 1443)

Provides for stakeholder input into the use of quality measures for purposes of payment. Each year, the Secretary shall make public a list of measures being considered for usage for payment systems. Under a transparent process, a consensus-based entity shall convene a multi-stakeholder group to provide recommendations for the usage of measures in a timely fashion, and the Secretary shall consider these recommendations.

Application of quality measures (Section 1444)

Ensures that quality measures selected by the Secretary are endorsed by a consensus-based entity with a contract with the Secretary under section 1890, except in certain circumstances, e.g., the measure has not been evaluated and no comparable endorsed measure exists. If the Secretary chooses to use a measure that the entity considers but does not endorse, the Secretary shall include the rationale for continued use in rulemaking. Applies this standard to inpatient hospitals, physician services, and renal dialysis services. Note: this may affect only renal dialysis providers operating in nursing homes.

Other Issues

Establishment of A National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support (CLASS program) (Section 2581)

Establishes a new, voluntary, public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day. For institutionalized eligible beneficiaries enrolled in Medicaid, the beneficiary shall retain 5% of the cash benefit (in addition to the Medicaid personal needs allowance) and the rest shall be applied toward the facility's cost of providing care. Medicaid shall be secondary payor. For beneficiaries receiving home- and community-based services, they retain 50% of the cash benefit and the remainder shall be applied to the cost of the state of providing Medicaid assistance. Medicaid provides secondary coverage subject to various conditions. The definition of HCB services includes HCB services under Medicaid waivers and 1915(i) HCB State Plan Option.

Public Health Insurance Option

Payment rates for items and services (Section 323) The Secretary shall negotiate payment for health care providers and items and services, including prescription drugs, for the public health insurance option. Secretary shall negotiate in manner so that payment rates are not lower in aggregate than rates under Medicare and not higher in aggregate than average rates paid by other Qualified Health Benefits Plans. Medicare providers are presumed to be participating in

the public option unless they opt out. There are no penalties for opting out and providers have at least a one-year period prior to the beginning of the pubic option to opt out. There shall be no administrative or judicial review of payment rates. Most nursing homes can be part of the Public Option provider network unless they opt out.

Modernized payment initiatives and delivery system reform (Section 324) The Secretary shall evaluate the progress of payment and delivery system reforms and apply them to the public option and how it pays for medical services to promote better quality and more efficient use of medical care. Such payment changes must seek to reduce cost for enrollees, improve health outcomes, reduce health disparities, address geographic variation in the provision of medical services, prevent or manage chronic illnesses, or promote integrated patient-centered care. The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. The Public Option can institute bundling and other new payment options.

Workforce

Title VIII Nursing Workforce Development Programs(Section 2221)---The legislation makes a number of changes to the Title VIII Nursing Workforce Development Programs, including increasing loan repayment benefits for nursing students and faculty and removing the cap on awards for nursing students pursuing a doctoral degree.

Health Workforce Evaluation and Assessment (*Sections 2261, 2271)*--The bill also establishes an Advisory Committee on Health Workforce Evaluation and Assessment to assess, evaluate, and advise the Secretary on the adequacy and appropriateness of the nation's health workforce and make recommendations to the HHS Secretary and Congress on workforce policies to meet the nation's workforce health and health care needs. In addition, the Secretary is required to collect data on the supply, diversity, and geographic distribution of the Nation's health workforce, including individuals participating in various federal workforce programs.

Long Term Care and Family Caregiver Support (Section 2589)--Creates advisory panel and a pilot program focused on improving the working conditions and training for the long-term care workforce.

Department of Labor Web site on Health Care Labor Market and Related Educational and Training Opportunities (Section 2590)-- Requires the Secretary of Labor to establish a web site that would serve as a clearinghouse of information on the health care labor market, including educational and training opportunities and financial aid information.

Department of Labor Online Health Workforce Training Programs (Section 2591)-- Establishes a new program for the Secretary of Labor to support online training of health care workers. Authorizes $50 million for each of FY 2011 through FY 2020 to carry out this program.