

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

The Patient Protection and Affordable Care Act (PPACA) adopts reforms that affect practically every aspect of the country's health care system. This report focuses on policy changes related to the continuum of care for older people—specifically long term services and supports (LTSS) and chronic care coordination. For this analysis, the Act's major provisions in these areas are organized into five categories: 1) national insurance for long term services and supports; 2) Medicaid options and incentives to expand LTSS; 3) other LTSS provisions; 4) chronic care coordination; and 5) nursing home reforms.

The Community Living Assistance Services and Supports (CLASS) program establishes a national voluntary insurance program for long term services and supports. Its implementation will involve a broad array of federal and state policymakers as well as consumer interests, providers and the private sector. Many of the other provisions create opportunities to promote better care coordination and service integration through the adoption of new options and delivery systems models. Looking ahead toward implementation of health care reform, states, working together with federal officials, communities, and consumer interests, will need to assess these new opportunities to determine which ones can best advance their policy agendas for improving LTSS and chronic care for persons with complex needs.

NATIONAL ACADEMY
for STATE HEALTH POLICY

Briefing

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Long Term Services and Supports and Chronic Care Coordination: *Policy Advances Enacted by the Patient Protection and Affordable Care Act*

BY DIANE JUSTICE

SUPPORTED BY THE SCAN FOUNDATION

The national debate on health care reform generated significantly more public awareness of gaps in the continuum of care for older people than most observers ever anticipated. As a result, the Patient Protection and Affordable Care Act (PPACA) includes several important policy changes that will improve the delivery of health care and community supports for older people. A ground-breaking new national long term care insurance program has been enacted, as have a myriad of small, incremental changes to existing long term services and supports programs. In other respects, the recent scrutiny of our health care delivery system acknowledged, but did not significantly address, shortcomings in meeting the needs of people with multiple chronic conditions. Instead, a set of demonstrations have been enacted to test delivery system reforms for improving chronic care coordination for older people.

In the midst of the health care reform deliberations, the National Academy for State Health Policy (NASHP) held its annual policy conference with the theme "All Aboard! Destination—Health Reform." A panel of national experts

was convened to provide an early read on the initial long term and chronic care issues being addressed by the major Congressional health care reform bills.¹ This paper moves beyond the panel's original comments to report on the long term and chronic care delivery systems provisions that were ultimately incorporated into the final health care reform bill. Consistent with the panelists' focus, the provisions presented here are analyzed to some extent through the lens of state policymakers.

Dr. Bruce Chernof, President and CEO of The SCAN Foundation, set the stage for the panel's discussions by presenting the case for needed reforms in long term care policy. He noted that close to one-third of Medicaid spending—\$101 billion—is devoted to long term services and supports. Furthermore, Medicare spends almost 4.5 times more per person on older people with three or more limitations in activities of daily living as compared to those with none; thus, high public sector expenditures to meet chronic care and long term care needs are closely linked. Despite significant levels of public spending, thirty-five percent of long term care is privately financed.

Further underscoring the imperative for health care reform to address long term care, Dr. Chernof reported on the results of a national poll conducted for The SCAN Foundation that indicate:²

- Nearly eight in ten Americans (79%) are more likely to support health care reform that includes improved coverage for home and community based long term care services.
- Nearly the same proportion (78%) of Americans say health care reform would benefit them personally if it included improved coverage for these services.
- Additionally, 79% of Americans are concerned about their ability to pay for long term care in the future.
- Concern about affording long term care services as well as support for improving coverage as part of health reform spans majorities of all demographic groups, including gender, age, income, and party affiliation.

CHRONIC AND LONG TERM CARE POLICY ENACTED UNDER HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010 includes provisions that affect practically every aspect of the country's health care system. This report focuses on policy changes related to the continuum of care for older people—specifically long term services and supports (LTSS) and chronic care coordination. For this analysis, the Act's major provisions in these areas are organized into five categories: 1) national insurance for long term services and supports; 2) Medicaid options and incentives to expand LTSS; 3) other LTSS provisions; 4) chronic care coordination; and 5) nursing home reforms.

NATIONAL INSURANCE FOR LONG TERM SERVICES AND SUPPORTS

The Community Living Assistance Services and Supports (CLASS) Act creates a new federally administered, voluntary insurance program financed by individual enrollees. Unlike the modest incremental Medicaid long term services and supports provisions adopted as part of health care reform, this program establishes a completely new public-private approach to financing and accessing LTSS. Program premiums will be fully paid for by individual workers through payroll deductions. To promote a high rate of program participation, individuals whose employers agree to participate in premium withholding will automatically be enrolled, while retaining the right to opt-out of the program at any time. Alternative methods for making premium payments will be established for persons working for non-participating employers.

Premium amounts will be set by the Secretary of the U.S. Department of Health and Human Services (DHHS) at a level necessary to maintain program solvency. No underwriting based on pre-existing conditions can be used to prevent an individual from enrolling in the CLASS program or to determine monthly premiums. To qualify for benefits, individuals must have paid premiums for five years, have a disability expected to last at least ninety days, and meet the functional and/or cognitive eligibility criteria established by the Secretary. The cash benefit amount paid to eligible

enrollees will vary based on individual measures of disability and is not subject to any lifetime or aggregate limits. Enrollees will decide for themselves how to make the best use their cash benefits.

Although the CLASS program is federally administered, it will interact with state LTSS programs in several ways. DHHS will contract with state and local entities to provide enrollees advice and counseling on obtaining and coordinating LTSS; many of these entities will likely be the same ones that perform these functions for participants in existing state programs. Consistent with their roles in state LTSS systems, State Protection and Advocacy Agencies will be charged with helping CLASS enrollees access appeals processes and with providing other individual advocacy as needed. State Disability Determination Agencies will establish enrollees' eligibility for CLASS benefits; state aging, developmental disabilities and Medicaid agencies perform this function in state LTSS systems. Within two years of enactment, states are required to assess whether there is an adequate supply of entities that could serve as fiscal agents to provide employment-related services for personal attendants working for CLASS beneficiaries, and if not, designate or create needed agents.

State Medicaid agencies, DHHS, and the Treasury Department will need to establish links between their enrollment and payment systems to identify joint beneficiaries and transfer funds between agencies. CLASS beneficiaries receiving Medicaid financed home and community based services and supports will retain 50 percent of their CLASS payment, with the balance applied to their Medicaid service and supports costs; 95 percent of the CLASS benefit payable to Medicaid eligible institutional residents will be allocated to their care. In both instances, Medicaid will finance all remaining service and supports costs beyond the CLASS benefit amount.

MEDICAID OPTIONS AND INCENTIVES TO EXPAND LONG TERM SERVICES AND SUPPORTS

The PPACA contains several provisions that could potentially expand the availability of Medicaid community based long term services and supports by establishing new optional benefits states can choose to add to their Medicaid state plans and /or by providing states with

financial incentives to increase Medicaid funding for existing programs through targeted enhanced matching rates.

State Balancing Incentive Payments Program:

Increases in federal financial participation for state expenditures on Medicaid 1915(c) Home and Community Based Services (HCBS) waivers, PACE programs, and home health and personal assistance under the Medicaid state plan will be provided to states as a financial incentive to adopt certain structural changes in their long term services and supports systems. To qualify for enhanced federal matching payments, a State must submit an application to the Secretary of DHHS which 1) outlines its plans to expand Medicaid funding for non-institutional services and supports, and 2) describes its approach to making three major structural changes in its delivery systems.

The three required structural reforms are: 1) establishment of a "No Wrong Door— Single Entry Point System" that creates a statewide system of access points for long term services and supports; 2) adoption of conflict-free case management; and 3) application of core standardized assessment instruments for determining eligibility for non-institutional services and supports used in a uniform manner throughout the state. States must also collect data on service utilization, core quality measures, and consumer outcome measures. Participating states may not adopt more restrictive standards and methodologies for determining eligibility for Medicaid home and community based services and supports than were in effect December 31, 2010.

Participating states with less than 25 percent of their fiscal year 2009 Medicaid LTSS expenditures allocated to non-institutional services and supports would receive a five percentage point increase in Federal Medicaid Assistance Payments (FMAP) applied to all Medicaid spending for home and community based services and supports during fiscal years 2011-2015. They will be expected to achieve a target of 25 percent of Medicaid LTSS spending devoted to HCBS by 2015. All other states in which less than 50 percent of Medicaid LTSS spending was for non-institutional supports would receive FMAP incentive payments of two percentage points and have a target of 50 percent spending on HCBS by 2015.

All incentive payments received by states must be used to expand the availability of Medicaid home and community based services and supports. Up to \$3 billion is available for Medicaid matching incentive payments which, in effect, will directly finance an increase in publicly funded community based LTSS. The State Balancing Incentive Program goes into effect October 1, 2011.

Community First Choice Option—Medicaid State Plan Option for Attendant Services and Supports:

This new state plan option for home and community based attendant services and supports finances a broad range of activities to assist eligible persons with activities of daily living, instrumental activities of daily living, and health-related tasks. Beyond an expansive definition of attendant services and supports, the Act specifically permits expenditures for items such as one month's rent, utility deposits, and household furnishings to help individuals transition from institutions to community living and for supports that can substitute for human assistance. Specifically excluded are expenditures for assistive technology devices (other than those that can substitute for human assistance), medical supplies and equipment, home modifications, and vocational rehabilitation. Attendant services and supports may be provided by agencies or through alternative models such as vouchers, direct cash payments or fiscal agents. To be eligible for this new option, individuals must require an institutional level of care.

This state plan option adds to the existing Medicaid authorities states can use to finance LTSS for older people and persons with disabilities. In comparison to Medicaid HCBS waiver policy, the Community First Choice Option does not mandate budget neutrality, meaning that state spending is not held to an amount that would have otherwise been spent for institutional care. States cannot set ceilings on the number of persons who can receive supports or offer benefits on less than a statewide basis, as they can under HCBS waivers.

In contrast to the existing Medicaid state plan personal assistance option, the Community First Choice Option enables states to adopt the more generous institutional eligibility criteria of up to 300 percent

of the income threshold for Supplemental Security Income (SSI) benefits, thereby equalizing access to attendant services and institutional care based on financial criteria. States picking up this option will receive a six percentage point increase in their FMAP rate for state plan attendant services and supports expenditures. During the first full fiscal year in which an attendant state plan amendment is implemented, a state must maintain the same level of Medicaid expenditures for individuals with disabilities or elderly individuals as in the previous year. Community First Choice Option becomes effective on October 1, 2011.

Money Follows the Person Rebalancing Demonstration: Established by the Deficit Reduction Act of 2005, this demonstration encourages states to identify Medicaid recipients who have lived in an institution for at least six months and want to return to community living. When a state facilitates such transitions, it receives an enhanced FMAP for the Medicaid home and community based services and supports it provides to program participants during the first year of their relocation. The increased Medicaid funds states earn under the demonstration must be reinvested in their LTSS to increase the availability of community-based options. Thirty states are currently participating in the demonstration.

The Money Follows the Person demonstration was originally scheduled to end in 2011. The health reform statute extends it through 2016 and reduces the institutional length of stay needed to qualify for enhanced HCBS matching payments from 180 days to 90 days, after subtracting any days covered by Medicare's skilled nursing home benefit. This change will increase the number of persons who meet the demonstration's qualifying criteria, thereby generating additional Medicaid matching funds earmarked for expansion of community based services and supports. An additional \$2.25 billion is appropriated through FY 2016, bringing the demonstration's total funding level to \$4 billion. These amendments become effective on April 22, 2010.

Medicaid Home and Community Based Services State Plan Option: The Deficit Reduction Act of 2005 allowed states to amend their Medicaid state

plans to add home and community based services (HCBS) as an optional benefit. The HCBS optional state plan benefit, authorized by Section 1915(i) of the Social Security Act, has features that make it a hybrid between a Section 1915(c) Medicaid HCBS waiver program and a regular Medicaid state plan optional service (such as the optional personal assistance service).

Similar to 1915(c) waivers, the 1915(i) HCBS optional state plan benefit encompasses multiple services; however, the scope of services covered by the 1915(i) state plan option was more limited than could be authorized through waivers. In contrast to waiver program eligibility criteria, the 1915(i) HCBS optional state plan benefit does not require persons to need an institutional level of care—in fact states must establish less stringent functional criteria than they use for waivers. Thus, states were not permitted to adopt the more generous institutional income standard of 300 percent of SSI permissible under the 1915(c) waiver program. The HCBS state plan benefit, as a result, did not expand the population a state can serve beyond the group it could already reach through state plan personal assistance.

Given these various program policies, the 1915(i) HCBS optional state plan benefit did not provide states with a vehicle for funding community based supports that significantly improves upon the array of existing Medicaid authorities. Only a handful of states have adopted it, all of which have established small specialized programs.

With the intent of improving the 1915(i) HCBS state plan option so more states will adopt it, the PPACA broadens the scope of covered services. In addition, states may use this authority to serve the same population that meets both the functional and financial criteria of their existing HCBS waivers. These amendments modify the niche that the 1915(i) HCBS state plan option could fill within state systems of long term services and supports; however, because the PPACA eliminates states' ability to establish program enrollment ceilings and requires statewide coverage, few states will be able to adopt this option within the current budget climate. Provisions amending Medicaid Section 1915(i) become effective on October 1, 2010.

OTHER LONG TERM SERVICES AND SUPPORTS PROVISIONS

Spousal Impoverishment: Currently a spouse living in the community can retain some joint income and assets without jeopardizing the ability of the other spouse to become financially eligible for Medicaid nursing home benefits. Beginning in 2014, the PPACA mandates the application of these spousal impoverishment protections to persons whose spouses' qualify for Medicaid funded home and community based services and supports.

Long Term Services and Supports Workforce: A three year initiative designed to strengthen the direct-care workforce that provides long term services and supports to older people and persons with disabilities is established in the Patient Protection and Affordable Care Act. Specifically, the statute enumerates a core set of 10 competencies for personal or home care aides. The Secretary is required to competitively award funds to six states that will: 1) demonstrate approaches to implementing training that advances the core competencies; and 2) develop training protocols, including a certification test for personal or home care aides who have completed the core competency training.

Using an experimental or control group testing protocol, the Secretary will evaluate the impact of the core training on mastery of the personal aides' job skills; their job satisfaction; and beneficiary and family satisfaction with services and supports. Up to \$5 million is available for each fiscal year from 2010 through 2012 to carry out the demonstration projects.

Long Term Care Employee Background Checks: A nationwide program is established to conduct national and state background checks on LTSS provider employees who have one-on-one contact with persons receiving supports. Covered by the new requirements are employees of a wide range of institutional and community-based entities, including nursing facilities, intermediate care facilities for the mentally retarded (ICF/MRs), assisted living residences, and providers of home health, hospice, personal assistance, and adult day care services. Up to \$160 million is available to carry out the program for fiscal years 2010-2012.

Aging and Disability Resource Centers: The Act appropriates \$10 million a year for five years from

2010 to 2014 to expand Aging and Disability Resource Centers to serve as community access point for persons seeking long term services and supports.

CHRONIC CARE COORDINATION

Achieving better care coordination for persons with multiple chronic conditions is an articulated goal of a diverse set of new initiatives enacted through the PPACA. Included are strategies to more closely align Medicare and Medicaid policies on behalf of dual eligibles; enhance linkages between health and LTSS; improve provision of primary care to persons with multiple chronic conditions; and smooth transitions from one care setting to another. Mostly these initiatives are designed as demonstrations within the Medicare program to test new delivery systems models and/or payment reforms. In some instances similar pilots are established in the Medicaid program.

Federal Coordinated Health Care Office: A new statutory authority designed to advance better care coordination tackles some of the most significant policy barriers to improving health and LTSS delivery systems for older people. The PPACA establishes a new office within the Centers for Medicare and Medicaid Services charged with a broad agenda for improving coordination between the Medicare and Medicaid programs on behalf of dual eligibles. The Office's eight statutory goals range from a beneficiary focus on improving the quality of health care, long term care services, care continuity and transitions to an administrative focus on eliminating regulatory conflicts between the Medicare and Medicaid programs.

Examples of the Office's responsibilities include: providing states, special needs plans, physicians, and other relevant entities with tools to better align the two programs' benefits; supporting state efforts to coordinate health and LTSS for dual eligibles; and providing support for coordination of contracting and oversight by states and CMS related to integration of the Medicare and Medicaid programs. The Secretary is required to submit an annual report to Congress with recommendations for legislation that would improve care coordination and benefits for dual eligibles.

Medicare Special Needs Plans: Special Needs Plans (SNPs) are a type of Medicare Advantage plan permit-

ted to target enrollment to beneficiaries who are dual eligibles, nursing home residents, and/ or have a chronically disabling condition. As of January 2009, there were 697 SNPs, of which 405 were designated as dual eligible plans. Not all dual eligible SNPs have contracts with Medicaid agencies and among those that do, the scope of benefits covered varies considerably. Some states contract with dual eligible SNPs as a way to improve coordination of Medicare and Medicaid benefits and an increasing number of states contract with SNPs to integrate health and LTSS for dual eligibles.

The statute reauthorizes Special Needs Plans through December 31, 2013, and maintains through December 31, 2012, the current moratorium on geographic expansion by dual eligible SNPs that do not have Medicaid contracts. At that time, all dual eligible plans operating in a state must have contracts with the state Medicaid agency.

The PPACA also authorizes a new risk adjustment and enforces enrollment criteria that more closely align SNP plans with the characteristics of their members. Beginning in 2011, it permits the Secretary to apply the PACE frailty adjustment to payment rates for fully integrated SNPs that have both capitated Medicaid contracts that include long term services and supports and average frailty levels similar to PACE programs. It also specifies a process for transitioning to other Medicare programs current SNP enrollees who do not meet the definition of their plans' designation (dual eligible, institutionalized, or chronically ill). By 2012 the Act requires SNPs to be approved by the National Committee for Quality Assurance.

Medical (Health) Homes: The PPACA creates a federal grant program to establish community health teams charged with supporting patient-centered medical homes, an enhanced model of primary care. Eligible grant recipients are states, state designated entities, and Indian tribal organizations. The interdisciplinary community health teams funded under this program must in turn contract with primary care providers to deliver support services such as care coordination, chronic disease management, care planning, and similar functions.

Beginning January 1, 2011, the Act also gives states the option of amending their Medicaid state plans to fund medical home services, components of which include

comprehensive case management, care coordination and health promotion, transitional care, patient and family support, referral to community and social services, and use of health information technology to link services. Statewide and comparability requirements may be waived and states will receive an enhanced FMAP of 90 percent for medical home services expenditures made during the first two years the state plan amendment is in effect. Beginning January 1, 2011, the Secretary may award planning grants to states for development of a medical home state plan amendment. Total grant awards may not exceed \$25 million.

Eligible medical home participants must have: 1) at least two chronic conditions; or 2) one chronic condition and be at risk for another one; or 3) have a serious and persistent mental health condition. They can select as their medical home: 1) a designated provider (generally a physician, practice or clinic); or 2) a team of health care professionals; or 3) a health team as described above. States must require hospitals participating in the Medicaid program to establish procedures for referring to medical homes those Medicaid recipients who meet the medical home participation criteria and are seeking treatment in an emergency room. States must also track avoidable hospital readmissions and calculate savings resulting from improved chronic care coordination provided through medical homes.

The final health care reform bill did not adopt the revisions to the Medicare medical home demonstration advanced in the House bill. It would have repealed a prior Medicare medical home demonstration authority enacted by Congress in 2006 and replace it with a new design that would include new options for delivering medical home services. The Senate bill, which became the primary vehicle for passage of health care reform, did not amend or repeal the prior demonstration. However, it did place “patient-centered medical home models for high need individuals” first on its list of potential models for testing by the new Center for Medicare and Medicaid Innovation in CMS.

Independence at Home Demonstration Program:

This new Medicare demonstration will test the use of independence at home medical practices comprised of primary care teams of physicians, nurse practitioners, and others to deliver care to high need populations at

home and coordinate care across all treatment settings. Participating Medicare beneficiaries must have two or more chronic illnesses; have had in the past 12 months a non-elective hospital admission and received rehabilitation services in a skilled nursing facility, other post-acute setting or at home, or received skilled home care services; and have two or more functional limitations in activities of daily living. Enrollment is limited to 10,000 beneficiaries.

An independence at home medical practice will be eligible for incentive payments if: 1) it meets quality performance measures established by the Secretary; and 2) the annual Medicare expenditures of the beneficiaries it serves are less than projected target spending levels. The demonstration will be evaluated on the basis of both cost effectiveness and quality measures, such as beneficiary health outcomes and reductions in preventable hospitalizations and readmissions. The Secretary must implement the demonstration no later than January 1, 2012.

National Pilot Program on Payment Bundling: The PPACA establishes a pilot program to determine the most clinically appropriate ways to coordinate post-acute care after a Medicare beneficiary has been hospitalized for one of 10 specific conditions. For each episode of care, the payment will cover acute care hospital services, physicians’ services, hospital outpatient services, and post-acute services such as home health, skilled nursing facility services, and inpatient rehabilitation services. Financing for transition support services such as care coordination, medication reconciliation, and discharge planning will also be incorporated into the payment methodology. An episode of care is defined as including the three days prior to hospital admission, the hospital length of stay, and the 30 days following discharge.

The pilot is to begin no later than January 1, 2013, and will be evaluated based on measures of cost effectiveness, quality, and beneficiary access to care. At any point after January 1, 2016, the Secretary may expand the pilot’s duration and scope if, along with the CMS Chief Actuary, she determines that the expansion would be cost effective and either improve or not reduce quality of care.

A Medicaid bundling payment demonstration to be conducted in up to eight states is also established in the health reform statute. A bundled Medicaid payment will be made for a specific episode of care to cover hospital services, concurrent physician services, and other services proposed by the state and approved by the Secretary. Participating hospitals are required to have robust discharge planning programs to ensure that beneficiaries have access to appropriate post-acute care. The demonstration will be conducted from January 1, 2012 through December 31, 2016.

Community Based Care Transitions Program: The PPACA establishes a new Medicare demonstration that provides transition services at competitively selected locations to beneficiaries at high risk of either rehospitalization or a substandard transition to post-acute care. Community based organizations together with hospitals having high readmission rates may apply to CMS for funding to provide transition supports that extend beyond required hospital discharge planning processes. The program will be carried out over a five year period beginning January 1, 2011. The Secretary may expand its duration and scope if she determines it would reduce Medicare spending without reducing quality.

Accountable Care Organizations: The Medicare Shared Savings Program established by the PPACA will implement payment models designed to provide Accountable Care Organizations (ACOs) with financial incentives to reduce the growth of Medicare expenditures and improve beneficiary health outcomes. ACOs are groups of physicians, other providers, and suppliers that have legal relationships enabling them to share and distribute any financial incentive payments awarded under the program. Participating ACOs must be willing to be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to them. They must also include primary care professionals in numbers sufficient to serve their assigned Medicare beneficiaries; define processes to promote evidence-based medicine and patient engagement; report on quality and cost measures; and coordinate care.

The Secretary may make shared savings payments to ACOs that meet quality performance standards using:

1) a performance target model that measures changes in the Medicare expenditures of an ACO's assigned beneficiaries against an organizational-specific target rate of growth; or 2) a partial capitation model; or 3) any other approach to performance payment developed by the Secretary.

NURSING HOME REFORMS

The PPACA adopts a multi-pronged strategy to strengthen the public accountability of nursing facilities. These extensive "Nursing Home Transparency and Improvement" provisions can be categorized according to three shared goals: 1) increase the public availability of information about the operation of individual nursing facilities; 2) create new approaches to enhancing compliance with federal requirements; and 3) increase responsiveness to residents' concerns.

Nursing Home Transparency and Consumer Information: Skilled nursing facilities (SNFs) and nursing facilities (NFs) will be required to disclose information on three aspects of their financial structures: 1) ownership identity and direct and indirect controlling interests; 2) members of the facility's governing body, including their relationship to the facility's financial organizational structure; and 3) the organizational structure of officers, directors, shareholders, partners and trustees who have ownership interests.

To highlight expenditures SNFs make for wages and benefits of direct care staff, Medicare cost reports will be revised to collect data in four categories: direct care services; indirect care such as housekeeping and dietary services; capital assets; and administrative costs. Both SNFs and NFs will also be required to report: 1) direct care staff employed in each position category; 2) resident census and case mix data; 3) employee tenure and turnover; and 4) hours of care provided per resident per day.

Improvements to the Nursing Home Compare website will include links to state survey and certification agency websites to provide the public with access to facility inspection reports and correction plans as well as postings of facility specific information on staffing characteristics, substantiated complaints, and adjudicated criminal violations. A new consumer rights page will provide sources of available nursing home data, a

description of the survey process, and state specific information on Long Term Care Ombudsman services.

New Approaches to Enhancing Compliance with Federal Rules: SNFs and NFs will be required to establish internal ethics and compliance programs designed to prevent and detect criminal, civil, and administrative violations. Program components include standards to guide employee actions, procedures to detect violations, and disciplinary mechanisms. The Secretary will conduct an evaluation of the nursing homes' ethics and compliance programs to determine if they led to changes in deficiency citations, quality performance, or other patient care quality measures. Facilities will also be required to establish an internal quality assurance and performance improvement plan which coordinates with other Medicare and Medicaid quality assurance activities.

The federal Residents' Bill of Rights currently requires facilities to provide residents with advanced notification of a facility's impending closure. The PPACA further

specifies notification and transfer processes that must be followed, including required components of a formal plan for resident transfer and relocation. Finally, a new pilot program will monitor large interstate SNF and NF chains with serious safety and quality of care problems.

Increased Responsiveness to Residents' Concerns: A standardized form for SNF and NF residents and their families to use in filling complaints with state survey and certification agencies and state Long Term Care Ombudsman Programs will be created along with a new state complaint resolution process. It will emphasize accurate tracking of complaints; procedures for determining complaint severity and investigating complaints; and deadlines for responding to complaints. Revisions to the entrance nurse aide training, competency and evaluation requirements will include dementia management training and patient abuse prevention. And demonstration programs will be funded to develop best practices for changing facilities' cultures and for using technology to improve resident care.

ENDNOTES

1 Long Term Care and Chronic Care Issues in Federal Health Care Reform session (October 2009). Panelists were Dr. Bruce Chernof, President and CEO, The SCAN Foundation; Anne Montgomery, Senior Policy Advisor, U.S. Senate Special Committee on Aging; JoAnne Lamphere, Director, AARP State Government Relations; Donna McDowell, Director, Wisconsin Bureau of Aging and Disability Services; and moderator, Kathy Leitch, Assistant Secretary, Aging and Disability Services Administration, Washington State Department of Social and Health Services. The PowerPoint presentations can be accessed at the National Academy for State Health Policy's website at <http://www.nashp.org/conference?page=4>.

2 National poll conducted for The SCAN Foundation by Lake Research Partners, June 2009. Accessed at The SCAN Foundation's website at <http://www.thescanfoundation.org/commissioned-work/new-poll-shows-americans-more-likely-favor-health-care-reform-if-it-improves-cover>

NATIONAL ACADEMY for STATE HEALTH POLICY

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Government Relations; Donna McDowell, Director, Wisconsin Bureau of Aging and Disability Services; and moderator, Kathy Leitch, Assistant Secretary, Aging and Disability Services Administration, Washington State Department of Social and Health Services.

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Portland, Maine Office:

10 Free Street, 2nd Floor, Portland, ME 04101
Phone: [207] 874-6524

Washington, D.C. Office:

1233 20th Street NW, Suite 303, Washington, DC 20036
Phone: [202] 903-0101