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The **Affordable Care Act** Proposes **New Provisions** to Build a Stronger **Continuum of Care**

The ACA has key components to provide the building blocks for a better continuum of care—one that is person-centered, offers individual control, improves quality, and integrates care across settings and providers.

The passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, lays the groundwork for wide-ranging reform of the continuum of care. This continuum, composed of the entire realm of primary, acute, rehabilitative medical, and supportive long-term-care services, is fragmented and unsustainable in its current form. The ACA affords us a vision of a future in which care is integrated across providers and settings.

Many of the ACA's provisions focus on improving the delivery of care for individuals with chronic conditions and disabilities—people who interact often with the health and long-term-care systems. In 2009, 145 million people, or almost half of all Americans, were living with a chronic condition such as diabetes, heart disease, or dementia. People with chronic conditions are the heaviest users of healthcare services and account for 84 percent of healthcare spending. Although the majority of these individuals is under age 65, the likelihood of developing such conditions increases with age. Too often, individuals with chronic conditions are subjected to care that is poorly coordinated and results in misinformation, great difficulty in navigating the healthcare system, unnecessary services utilization, and, ultimately, higher costs (Anderson, 2010).

This article describes a broad range of provisions within the ACA that aim to advance a framework and foundation for redesigning the healthcare delivery system to one that is person-centered, offers individual control, improves quality, and integrates care across settings and providers. Key provisions undergird health and long-term-care reform by improving the continuum of care within four domains: long-term-care insurance, home- and community-based services (HCBS) expansion, care coordination, and workforce reinforcement.

Long-Term Care with CLASS

This new era of system redesign begins with the ACA's CLASS (Community Living Assistance Services and Supports) provision, which, for the first time, provides members of the middle class with an affordable opportunity to

plan for and access supportive services in their choice of setting without impoverishing themselves to the level of Medicaid eligibility. The CLASS program fundamentally reframes the concept of long-term care from one of poverty, sickness, and loneliness to one of choice, community, and personal responsibility in the face of functional impairment.

A major challenge of the long-term-care system in its present state has been the inability of the near poor and the middle class to access the full range of available long-term-care services. The absence of comprehensive long-term-care financing, the low uptake of often costly private long-term-care insurance, and low savings rates among those nearing retirement have made the purchase of long-term-care services prohibitive for many individuals. To illustrate, eligibility for most publicly funded programs is restricted to those with the lowest income levels.

For quite some time, consumers have had to navigate a broken healthcare system.

Consider private long-term-care insurance: currently around six to seven million policies are in force, accounting for only about 7 percent of all long-term-care expenditures (Mulvey, 2011). Furthermore, about 42 percent of people in the United States ages 45 and older have saved less than $25,000 for retirement (Helman, Copeland, and VanDerhei, 2010). As a result, middle-class Americans are generally not prepared to pay the $6,000 per month for nursing home care or the $1,800 per month for part-time, in-home help (Genworth Financial, 2010). With so little saved, the middle class is particularly vulnerable, given the startling reality that 70 percent of Americans older than 65 will need long-term care at some point (Administration on Aging, 2010). A poll of California voters, commissioned by The SCAN Foundation and the UCLA Center for Health Policy Research, found that, regardless of party affiliation, people are worried about long-term-care costs and are unprepared to pay for these services (Lake Research Partners and American Viewpoint, 2010).

The CLASS program represents the beginning of a comprehensive long-term-care system based on the concept of a risk pool. It is a voluntary, publicly administered long-term-care insurance program for employed individuals, with no underwriting or exclusion for pre-existing conditions, and it offers a lifetime benefit for people who have significant difficulty in performing tasks of daily living. Premiums will be age-rated, with younger people paying considerably less and older adults paying more.

As the law is written, a vesting period will require enrollees to pay premiums for at least five years prior to receiving benefits. Benefits would be cash payments averaging no less than $50 a day and could be used to purchase various supports and services, including homecare, adult day programs, assisted living, or institutional care. Some may argue that a benefit of $50 a day does not go very far. However, this benefit equals approximately $1,500 a month and perhaps $18,000 or more in additional income over a year's time, which can supplement other resources to purchase services. Daily benefits provided by CLASS will offer a stable source of funding, increasing access to HCBS for those who would otherwise be unable to afford them.

Officially launched in January 2011, the Office of Community Living Assistance Services and Supports (CLASS Office) was established within the federal Administration on Aging. Under the leadership of the Assistant Secretary for Aging, Kathy Greenlee, the CLASS Office will oversee the implementation, administration, and management of CLASS, including the setting of premiums, the development and implementation of rules for enrollment and eligibility systems, and the payment of benefits (*76 Fed. Reg.* 5178). Today, many aspects of the CLASS program remain to be determined. The ACA requires the

Secretary of the U.S. Department of Health and Human Services (HHS) to announce the full details of the program by October 2012.

Expansion of HCBS: Pursuing Choice in Long-Term Care

The current network of long-term services and supports is not designed to meet the needs of the individual who is navigating the system. Recent polling work indicates that the majority of older Americans prefer to remain in their homes and communities as they age (AARP, 2010), yet the current publicly financed long-term-care system, by and large funded by Medicaid, is designed with an institutional bias for care. While the Medicaid program mandates that states cover nursing home care for eligible beneficiaries, HCBS do not enjoy that same mandatory status. Instead, most HCBS are considered "optional" state plan services or are provided under Medicaid waivers granted by the Centers for Medicare and Medicaid Services (CMS) in order to allow such services to be provided within a more limited scope than would be required of a state plan service.

While the ACA does not go so far as to include HCBS as mandatory state plan services, it allows states to expand HCBS offerings under Medicaid in two ways: by offering new optional benefits under their Medicaid state plans and by creating financial incentives to states to offer these new optional benefits through increased Medicaid federal matching rates.

Community First Choice option

The ACA establishes a new Medicaid state plan option, called Community First Choice, to offer community-based attendant services and supports to beneficiaries meeting the state's criteria for nursing facility eligibility. States that choose this option will receive a 6 percentage-point increase in their Federal Medical Assistance Percentage (or FMAP, the federal government's share of the Medicaid program). Not only will the Community First Choice cover the costs of personal attendant services and supports, but it expressly allows states to use funds to cover the costs of community transition supports (e.g., rent or utility deposits, first month's rent and utilities, bedding, basic kitchen supplies) for institutionalized individuals who meet the eligibility criteria and wish to return to the community. This option will be available to states in October 2011.

Medicaid HCBS state plan option

The Deficit Reduction Act (DRA) of 2005 allowed states to amend their Medicaid state plans to add HCBS as an optional benefit, authorized as Section 1915(i). Since its inception, few states have opted for the 1915(i) state plan option because of several programmatic limitations. As the DRA was originally enacted, states were unable to target 1915(i) services to specific populations with particular health and functional conditions, and only those with incomes at or below 150 percent of the federal poverty level could be eligible. The ACA revised the 1915(i) option by allowing states the opportunity to enroll Medicaid beneficiaries into HCBS with incomes up to 300 percent of the Supplemental Security Income amount and permits states to extend the full range of Medicaid benefits to those receiving services through the state plan option. States are also afforded the opportunity to target benefits to state-specified populations, such as individuals with qualified functional impairments. Additionally, the law now requires "state-wideness" of services under this option, meaning all who are eligible for services, regardless of geographic location, must have access. The changes to the 1915(i) state plan option became effective October 2010.

Money Follows the Person

The Money Follows the Person (MFP) demonstration, also established in the DRA, enables Medicaid beneficiaries who reside in a nursing facility to return to the community if they wish. For the year following the transition back into

the community, the state's FMAP is increased to provide necessary services to the beneficiary. The DRA required a six-month stay in a nursing facility before an individual's eligibility for the MFP program. The ACA extends the MFP demonstration through September 2016 and shortens the requirement for residency in a nursing facility from six months to ninety days. These changes became effective in April 2010, shortly after passage of the ACA.

For states already participating in MFP, the CMS does not require submission of a grant proposal for additional funds. For states that were not previously participating in MFP, a grant solicitation was released in June 2010. In February 2011, the HHS awarded new MFP grants to thirteen states, with grants totaling $621 million through 2016.

State Balancing Incentive Payments Program

The ACA offers new financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into home- and community-based settings. Eligible states will be those that spend less than 50 percent of their total long-term-care expenditures on HCBS. Qualifying states will receive an enhanced FMAP; those that spend less than 25 percent of their total long-term-care budgets on HCBS will receive a 5 percentage-point increase in their FMAP for related services, and those who spend between 25 percent and 50 percent of their total long-term-care budget on HCBS will receive an FMAP increase of 2 percentage points. States are permitted to increase the income eligibility standards for those seeking HCBS.

States choosing to participate in the Balancing Program will be required to establish a "single entry point–no wrong door" system to make it easier for beneficiaries to access services. These states must also have "conflict-free" case management services for the eligible beneficiaries and their caregivers, as well as a core standardized assessment instrument for eligibility determination and the development of care plans. This is a temporary program, scheduled to operate from October 2011 through September 2015.

The ACA and Care Coordination: Toward Person-Centered, Quality Care

The ACA created new programs to give incentives to providers and provider organizations for improving service arrangements for vulnerable populations. These programs revolve around Accountable Care Organizations (ACO) and medical homes and health homes.

Experts have not yet reached a consensus on the exact components of a successful ACO. At a minimum, the components consist of a local healthcare organization and a related set of providers including physicians, specialists, hospitals, and nonmedical supportive services. The primary goal is for this set of providers to be collectively accountable for improving the quality of healthcare for a defined population of people, while lowering costs.

Medicare Shared Savings Program

The ACA establishes the Medicare Shared Savings Program in which existing ACOs will be eligible to share in the savings accrued to the Medicare program, provided they meet quality-of-care targets and succeed in reducing patient care costs through better service coordination. This shared savings approach challenges inpatient and outpatient providers to work together instead of engaging in "cost-shifting" behavior. The program also provides an opportunity to strengthen the linkage between medical and supportive services.

While the focus of ACOs has been primarily on the integration of physician and hospital services, a broader set of providers—namely, the array of community-based supportive services—could be considered part of a multidisciplinary team in providing person-centered care. Often, the availability of supportive services in the community can mean the difference between

staying at home and an emergency room visit or a hospital admission or re-admission. Incorporating supportive services into the ACO's model of care will require greater outreach on the part of the ACO to community organizations in the local area, but the availability of these services could lead to overall savings. The Medicare Shared Savings Program is scheduled to begin January 2012.

Medical Homes and Health Homes

In addition to the Medicare Shared Savings Program, the ACA establishes a "medical home" program for Medicare beneficiaries with chronic conditions and offers states the option to enroll Medicaid beneficiaries in "health homes." Medical and health homes are models that include a "whole-person orientation" for coordination and responsibility of an individual's full array of healthcare services using a team-based approach. In its most enlightened iteration, the medical home or health home also includes direct connections to supportive services, recognizing that even the most chronically ill individuals live in their homes and communities, not in their doctor's office.

Four broad domains for improvement are long-term-care insurance, home- and community-based services expansion, care coordination, and workforce reinforcement.

The ACA creates a pilot program to establish and fund the development of medical homes for Medicare beneficiaries to be operated by the CMS. The pilot will be established by January 2013 and, based on the success of the pilot, may be expanded prior to the pilot's end date of January 2016. As of January 2011, states also have the option to enroll Medicaid beneficiaries with chronic conditions into a health home, based on the same care coordination concept. States who take up this option will receive an enhanced FMAP of 90 percent for two years.

New offices support system redesign

Supporting the establishment of ACOs and medical homes, health homes, and other system redesign activities are two new offices established within the CMS: the Center for Medicare and Medicaid Innovation (the Innovation Center) and the Federal Coordinated Health Care Office (the Duals Office). An important part of the ACA's foundation for improving the continuum of care is the continued pursuit of alternative models for financing services and organizing care through pilot testing. The CMS has a rich history of using demonstration programs to test different methods of arranging and paying for services through Medicare and Medicaid.

The Innovation Center, established in November 2010, creates the opportunity to develop, test, and expand innovative payment and delivery models that improve quality while controlling costs using a rapid cycle approach (*75 Fed. Reg.* 70274). When considering in which demonstration projects to engage, the Innovation Center will give greater weight to projects that address the key elements of person-centered care coordination. This may include individualized assessment focusing on the needs and preferences of beneficiaries, engagement with the appropriate medical and community-based providers using a team-based approach, and centering beneficiaries and their families in the middle of the care team.

The Duals Office, formally established in December 2010, brings together CMS officials to more effectively integrate Medicare and Medicaid policy structures in an effort to improve coordination between the federal and state governments for those who are dually eligible. The primary aims of this office are to improve the quality of healthcare and long-term-care services for individuals eligible for both Medicare and Medicaid ("dual eligibles"); to simplify

the processes for dual eligibles to access available services; to increase dual eligibles' understanding of and satisfaction with the services they receive; to eliminate regulatory conflicts between Medicare and Medicaid; and to improve coordination between the federal and state governments (*75 Fed. Reg.* 82405).

Programs for transitions and independence

Rounding out care coordination efforts in the ACA are the Community-Based Care Transitions Program and Independence at Home Demonstration. As gerontologists know all too well, social and environmental challenges at home following an acute-care stay can lead to rehospitalization just as easily as can poor medication reconciliation (Coleman et al., 2005).

The Community-Based Care Transitions Program provides grants to communities seeking to improve Medicare beneficiaries' experiences of returning home after a hospital or rehabilitative stay and reduce the likelihood of re-admission. Successful applications for these grant dollars must include a consortium of community-based service providers working in collaboration with hospitals and nursing facilities to implement an evidence-based care transitions intervention. In April 2011, the CMS began soliciting applications for the program.

For individuals who are homebound and have great difficulty visiting their doctor's office, the Independence at Home Demonstration will support physician- or nurse practitioner-led interdisciplinary team care in the home. Participating practices will be accountable for providing comprehensive, continuous, and accessible care to high-need populations in this environment, as well as coordinating healthcare across all treatment settings. This demonstration is currently under development, is slated to begin January 2012, and will operate for three years.

Support for the Direct-Care Workforce

A strong continuum of care cannot exist without a workforce well trained and sufficient in size to care for the population in need. In particular, there is a clear demand for a labor force that is appropriately trained to address the concerns of older adults. The direct-care workforce consists of certified nursing assistants, home health aides, and personal and homecare aides who provide the majority of paid, hands-on long-term-care and personal assistance received by older Americans and others living with disabilities or other chronic conditions. They assist clients with activities such as eating, bathing, and dressing, and they work in a variety of settings including nursing homes, private homes, and other community-based settings (PHI, 2010a).

Personal Care Attendants Workforce Advisory Panel

Building on recommendations from the Institute of Medicine's report *Retooling for an Aging America* (Institute of Medicine, 2008), the ACA addresses workforce training and development in several ways. The Personal Care Attendants Workforce Advisory Panel is part of the CLASS program and will be managed by the CLASS Office. This panel will advise the HHS Secretary and the team tasked with implementing CLASS on a variety of workforce issues related to personal care attendants, including the adequacy of the workforce to meet the potential demand, the wages and benefits of these workers, and access to services provided by these workers (*75 Fed. Reg.* 34140–34141). Nominations for this panel closed in June 2010, but the panel members have yet to be named.

National Health Care Workforce Commission

The National Health Care Workforce Commission was also established through the ACA to make recommendations to Congress, the administration, and states and localities about health workforce priorities and policies, including education and training, workforce supply and demand, and retention practices (PHI, 2010b). The provision of the ACA that established the Commission also specifically defined direct-care workers within the national health-

care workforce, thus requiring that the Commission consider this part of the workforce in their efforts. Nominations for the Commission closed in June 2010, and the members of the Commission were appointed in September 2010.

Grant programs for planning and training

In order to encourage states to directly engage with the workforce needs within their own boundaries, the ACA established competitive State Health Workforce Development Grants. One-year workforce planning grants of up to $150,000 were made available to thirty State Workforce Investment Boards with the requirement that the state match a percentage of the grant in cash or in kind. The planning grants allow states to analyze the local labor market, state policies and practices, and identify opportunities to strengthen the health workforce (HRSA, 2010a). In addition to these smaller grants, one two-year implementation grant was awarded to Virginia to support innovative approaches to increase the size of the appropriately trained health workforce (HRSA, 2010b). Both grants are administered by the Health Resources and Services Administration (HRSA).

The ACA established two grant programs to encourage a career path for the existing direct-care workforce and calls for the establishment of improved training for the next generation of direct-care workers. The Personal and Home Care Aide State Training Program, administered by HRSA, was established to fund up to six states for up to three years each to develop core competencies, pilot training curricula, and develop certification programs for personal and homecare aides. Under this program, California, Iowa, Maine, Massachusetts, Michigan, and North Carolina were awarded grants (HRSA, 2010c). The Nursing Assistant and Home Health Aide Program, also administered by HRSA, established a new three-year program for up to ten community college and community-based training programs to develop, evaluate, and implement demonstrations of a competency-based curriculum to train nursing assistants and home health aides. This program's goal is to promote career advancement of direct-care workers into nursing careers. The HRSA funded ten grants across nine states under this program in September 2010 (HRSA, 2010d).

The ACA Can Reinvent the Future of Long-Term Care

The ACA provides an opportunity to redirect the current health and long-term-care systems, which are highly fragmented and not designed to improve the experience of care for individuals. Key components in the ACA provide the building blocks to a better continuum of care—one that is person-centered, offers individual control, improves quality, and integrates care across settings and providers. The implementation of initiatives to improve care coordination, expand HCBS, support the direct-care workforce, and increase accessibility to long-term care through programs such as CLASS usher in relief to consumers who have long had to navigate a broken system. As the federal government is forced to confront the insolvency of programs such as Medicare that have buttressed the healthcare system, and states are facing unprecedented budget deficits putting major health programs at risk, the ACA provides many opportunities to reinvent the health and long-term-care systems to achieve greater sustainability.

There are many opportunities to reinvent the health and long-term-care systems to achieve greater sustainability.

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