Transforming the System of Care for Older Adults: The Affordable Care Act Five Years Later

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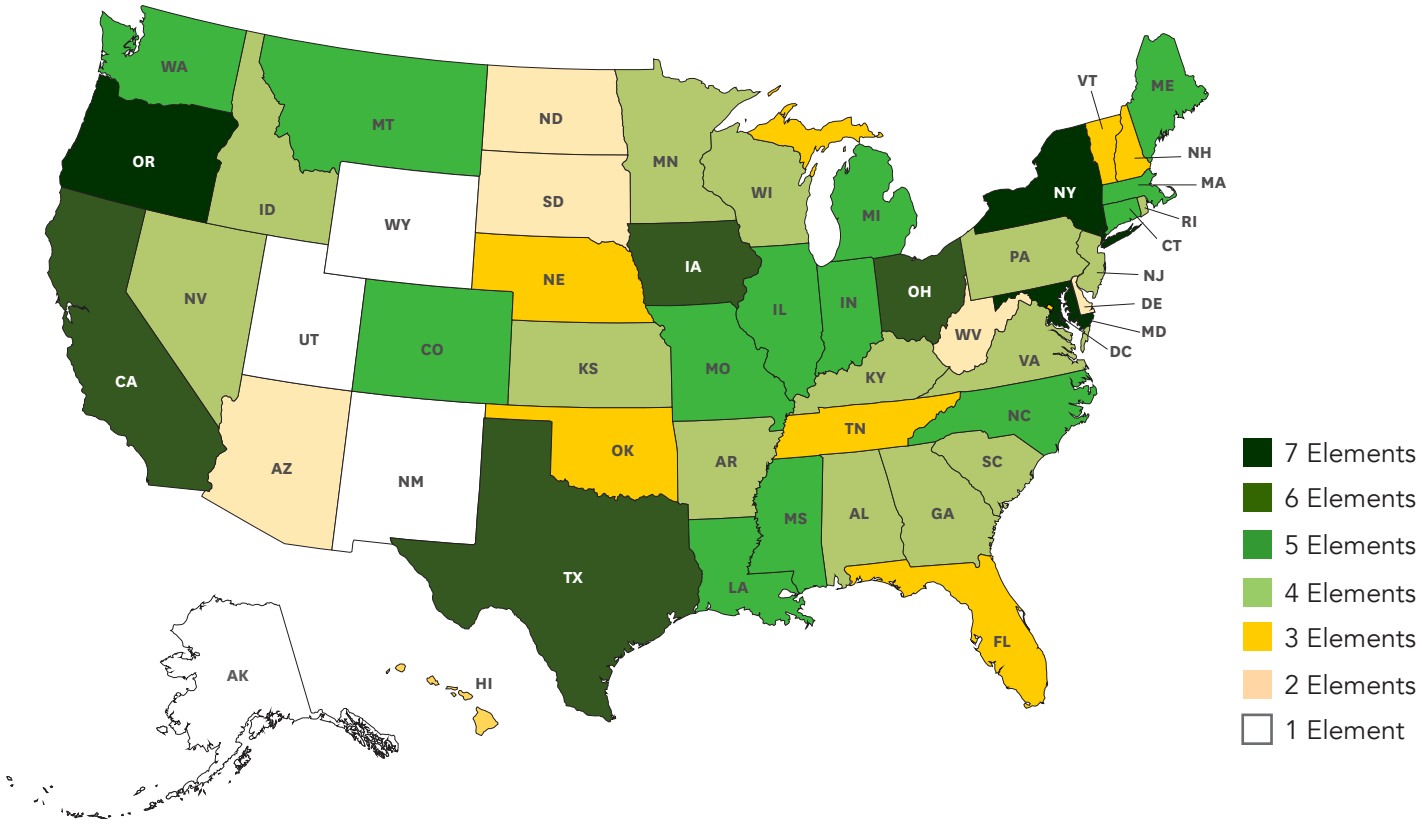
Signed into law in 2010, the *Patient Protection and Affordable Care Act* (ACA) included provisions to transform the health care delivery and long-term services and supports (LTSS) systems for older adults - providing the right services at the right time. This brief highlights implementation of eight elements of the ACA since its passage.

All 50 states are pursuing some level of change in their systems of care to better serve older adults.



Introduction

The *Patient Protection and Affordable Care Act* (ACA), signed into law on March 23, 2010, created landmark opportunities to transform our nation's health care delivery system. Recognizing that health care and social issues impact a person's health outcomes and well-being, key elements of the ACA sought to change the care delivery and LTSS landscape in an effort to help people access the right services and supports to meet their individualized needs. This is particularly important for older adults with chronic conditions and functional limitations who use the most services, have higher health care costs, and most often have poor health outcomes.[1] Currently, these individuals must navigate a highly fragmented system of care, receiving services from various providers who often do not communicate with each other. Given the rapid growth of America's aging population, particularly those over age 85 who often have substantial health and daily living needs, provisions in the ACA presented significant opportunities for transformation.

Implementing change of this magnitude is difficult and the ACA encountered many hurdles in its first five years. However, nearly all states are taking some action to increase access to coordinated care. This brief highlights several opportunities implemented since the law's enactment and describes additional action needed to move toward a health care system that promotes value for both people and payers.

Improving Care Coordination Across Providers

Historically, the fragmented system of care for older adults has led to confusion, poor health outcomes, and higher per-capita costs. The ACA established the following programs to test various approaches to coordinating medical care and LTSS systems to improve the quality of life for older adults while better managing costs.

- **Accountable Care Organizations (ACOs):** In an ACO, health providers (doctors, hospitals, nurse practitioners, physician assistants, and others) work together under a structured agreement, coordinating care to both improve quality and reduce medical costs. ACOs that are successful at meeting the quality performance measures and benchmark savings established by the Centers for Medicare and Medicaid Services (CMS) have the opportunity to receive a portion of the savings. Medicare has three types of ACO models (**Pioneer, Advance Payment, and Medicare Shared Saving Program**) designed to address capacity and increase accountability for quality and cost savings.

While most ACOs serve people with Fee-for-Service (FFS) Medicare, states are also exploring ways to establish similar delivery models in Medicaid.[2]

Currently, 424 ACOs serve 7.8 million Medicare beneficiaries.[3] In 2013, ACOs generated over $417 million in Medicare savings and qualified for shared savings payments of $460 million. This model has shown early improvements in overall quality and the patient experience – with Pioneer ACOs improving in 28 of 33 quality measures, and the Medicare Shared Savings Program improving on 30 of these measures.[4]

- **Community-Based Care Transitions Program (CCTP):** This program funds community-based organizations (CBOs) to provide services that improve transitions from inpatient hospitals to other care settings, reduce hospital readmissions, improve quality of care, and reduce Medicare costs for people at high-risk. Funding is available for five years. At capacity with 72 sites, the program's participating CBOs are predominantly comprised of Area Agencies on Aging as well as Aging and Disability Resource Centers. The **first annual evaluation report** noted several challenges in developing and implementing this radically new partnership model to improve how people returned home after a care episode. However, the report also identified successful CBOs as having four core characteristics: 1) serving older adults and people with disabilities; 2) providing both direct support services and coordination; 3) using the Care Transition Intervention model in combination with another transition model; and 4) having partnerships with one to two hospitals.[5,6]

> Due to provisions in the ACA, there are efforts in all states to better coordinate health care and LTSS for older adults.

- **Using a Health Risk Assessment to Support Care Coordination:** The ACA established a requirement for Medicare to cover, at no cost to the individual, an annual wellness visit that includes a health risk assessment (HRA). The HRA is intended to help create a plan of services used to prevent or manage chronic conditions.[7] The Centers for Disease Control and Prevention created **A Framework for Patient-Centered Health Risk Assessments** to address the content, design, and delivery of the HRA to better improve health outcomes. Based on findings from a recent report by Avalere Health, **Effective Management of High-Risk Medicare Populations**, managed health plans can use the HRA to assess both medical and non-medical characteristics (e.g., cognitive impairment, behavioral health,

lifestyle, social support) in order to identify high-risk beneficiaries who may benefit from care coordination efforts, ultimately improving care while lowering costs.

- **Duals Demonstration:** Individuals who are eligible for both Medicare and Medicaid, commonly referred to as "dual eligibles," face a fragmented system of care with little incentive for coordination due to separate funding sources. The ACA established the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation within CMS, charged with creating new integration models to improve service quality and manage the rising cost of care for people eligible under both programs. CMS launched the **Financial Alignment Initiative**, referred to as the "duals demonstration," to align funding and services between the two programs. States interested in pursuing this initiative can choose from a capitated model where the state, CMS, and a health plan enter into a three-way contract with the health plan responsible for coordinating care, or a managed fee-for-service model where the state and CMS enter into a contract. Twelve states have an approved memorandum of understanding with 11 states currently enrolling beneficiaries in these new models, and six states have proposals pending with CMS.[8,9] Several evaluation efforts are underway to understand the beneficiary experience as well as overall costs and utilization.

- **Health Homes:** The ACA created a Medicaid state plan option permitting states to develop health homes that coordinate primary and acute care, behavioral health services, and LTSS for people with multiple chronic conditions and/or a serious mental health condition. States can target services to populations based on geography, but cannot exclude dual eligibles. CMS provides states with a two-year, 90 percent enhanced federal match for health home services including care coordination, comprehensive care management, health promotion, comprehensive transition services, patient and family support, and referrals to community-based services. The enhanced match does not apply to standard Medicaid services provided by the health home.[10] As of November 2014, there were 20 approved health home models in 16 states, with 26 states planning to start or expand health homes in 2015.[11] In an **interim report to Congress** CMS highlighted early indicators of success related to care coordination, community-based service referrals, and patient empowerment.

Expanding Access to Medicaid-Funded Home and Community-Based Services

The ACA includes several opportunities for states to provide LTSS to individuals in the community rather than in an institution. These programs focus on an individual's daily function, providing services that help people work toward their goals and live in the setting of their choice.

- **Community First Choice Option (CFC):** In effect since October 1, 2011, CFC allows states to use a Medicaid state plan option to provide community-based attendant services to individuals who meet the Medicaid and level-of-care eligibility standards. Services are provided through an agreed upon person-centered plan based on a functional needs assessment with a focus on self-direction. In addition, states can use CFC to fund back-up systems to ensure continuity of services and supports (e.g., pagers, electronic devices), voluntary training on managing attendants, costs related to transitioning from an institution to the community (e.g., security deposits, supplies, etc.), and expenses to address a need identified in the service plan that increases independence or substitutes for human assistance. As an incentive, states are given a six percent increase in the federal match for services provided under CFC.[7,12-14]

  Forty-five states and the District of Columbia have taken advantage of opportunities in the ACA to rebalance the LTSS system by increasing access to HCBS.

  As of December 2014, eight states are participating in CFC: California, Maryland, Montana, and Oregon have state plan amendments approved by CMS, while four other states are awaiting approval. California used CFC to enhance the In-Home Supportive Services (IHSS) program, California's self-directed personal attendant services, to offer skills training and reach additional people requiring an institutional level of care. Connecticut and Washington plan to participate in 2015. Arizona and Louisiana showed interest, but later withdrew their proposed amendments.[15]

- **Section 1915(i) Home and Community-Based Services (HCBS) State Plan Option:** The ACA includes an amendment to Section 1915(i) of the Social Security Act to remove barriers to providing HCBS. States can now include HCBS within their Medicaid State

Plan instead of developing Medicaid waiver programs, enabling a greater reach to provide HCBS to individuals needing support to live in the community. Under the 1915(i) HCBS state plan option, states can target the HCBS benefit to specific groups, create a new Medicaid eligibility group for those who receive state plan HCBS, define the services included, and allow for self-direction. The benefits must be statewide, and states cannot cap the number of people served.[7,16]

Currently, 15 states have utilized the 1915(i) HCBS state plan option to provide HCBS services. The District of Columbia is awaiting approval from CMS, and five states have indicated plans to participate in 2015. States have predominantly used this option to target benefits to people with mental illness or those with developmental disabilities. California has used 1915(i) to expand the services provided to people with developmental disabilities who need less than an institutional level-of-care.[17,18]

The Money Follows the Person demonstration has helped over 40,500 people transfer out of institutional settings to live in the community.

- **Money Follows the Person Rebalancing Demonstration (MFP):** Originally authorized under the Deficit Reduction Act in 2005 and extended through the ACA, the MFP demonstration provides state Medicaid programs the flexibility to support individuals who transition from institutions into the community by providing **innovative HCBS** that would not otherwise be funded through Medicaid. States receive an enhanced federal match for HCBS funded under MFP, and are required to use those dollars to rebalance their LTSS system. The ACA extended MFP through September 2016 and changed the institutional length of stay eligibility criteria from a minimum of 6 months to 90 days. [7,19]

  As of December 2013, over 40,500 people transitioned from institutions back into the community across the 45 states and the District of Columbia participating in MFP.[19] **Evidence** indicates that the total expenditures of people using Medicaid declined after they transitioned from a long-stay in an institution to the community using HCBS, and that the additional HCBS provided through MFP may help prevent people from being re-institutionalized.[20]

- **Balancing Incentive Payment Program (BIP):** The ACA authorized grants to states through this program to increase access to HCBS by improving LTSS system structure,

creating care planning and assessment tools, and improving quality measurement and oversight. States participating in **BIP** receive an enhanced federal match on Medicaid HCBS to incentivize nursing home diversion and increase access. The amount of the enhanced match is based on a state's ratio of Medicaid LTSS spending on HCBS. In order to participate in BIP, states must have spent less than fifty percent of their Medicaid LTSS on HCBS, implement a no wrong door/single entry point to access services, provide conflict-free case management, have a core standardized assessment, and agree to spend the enhanced match dollars to expand HCBS.[21] Twenty-one states are participating in BIP. Thirteen states, including California, are not eligible.[22]

Table 1 shows that every state is implementing at least one of the ACA provisions outlined above or waiting for CMS approval for these opportunities.

Table 1: State Activity to Transform the System of Care

State	ACOs [23,24]	CCTP[5]	Duals Demos[9]	Health Homes[11,25]	CFC[15]	1915(i)[17]	MFP[26]	BIP[22]
AL	X	X		X			X	
AK	X							
AZ	X	X						
AR	X				X		X	X
CA	X	X	X		X	X	X	
CO	X	X	X			X	X	
CT	X		X			X	X	X
DE	X						X	
DC	X					X	X	
FL	X	X				X		
GA	X	X					X	X
HI		X	X				X	
ID	X			X		X	X	
IL	X	X	X				X	X
IN	X	X				X	X	X
IA	X	X		X		X	X	X
KS	X	X		X			X	
KY	X	X					X	X

State	ACOs [23,24]	CCTP[5]	Duals Demos[9]	Health Homes[11,25]	CFC[15]	1915(i)[17]	MFP[26]	BIP[22]
LA	X	X				X	X	X
ME	X	X		X			X	X
MD	X	X		X	X	X	X	X
MA	X	X	X				X	X
MI	X	X	X			X	X	
MN	X		X		X		X	
MS	X	X				X	X	X
MO	X	X		X			X	X
MT	X	X			X	X	X	
NE	X						X	X
NV	X					X	X	X
NH	X						X	X
NJ	X	X					X	X
NM	X							
NY	X	X	X	X	X		X	X
NC	X	X	X	X			X	
ND	X						X	
OH	X	X	X	X			X	X
OK	X		X				X	
OR	X	X	X	X	X	X	X	
PA	X	X					X	X
RI	X		X	X			X	
SC	X	X	X				X	
SD	X			X			X	
TN	X	X					X	
TX	X	X	X		X		X	X
UT	X							
VT	X			X			X	
VA	X	X	X				X	
WA	X	X	X	X			X	
WV	X						X	
WI	X			X		X	X	
WY	X							

Next Steps for Further Care Delivery Transformation

The ACA is a major statutory catalyst to improve access to and delivery of a more organized system of care with the three aims of improved care for Americans, improved population health, and lowering per-capita costs. Many of the programs and initiatives remain in the early stages with varying degrees of success, as implementation of this size and scale has proved challenging. Most of these opportunities require new contracts and/or commitments from organizations that may not have worked together in this manner. The intensity of engagement among these organizations and partnerships also affects success, which will be an important factor in early term or final evaluations of the policy implementation process. Continued efforts are critical, building on successes and lessons learned, including understanding which components work best to meet the range of needs among a diverse older adult population.

Below are policy recommendations for continuing efforts toward a more organized system of care to meet the needs of older adults:

- **Establish principles of person-centered care:** Person-centered care principles must be a central focus in order to ensure people are receiving the right services at the right time in line with their goals and values. However, person-centered care is defined differently across the system of care. The development of a clear definition and set of standards that reflect a partnership between the provider and individual in decision making and care management will provide an opportunity to gather information about each person's experience of the service system that is unique to their health, functional, behavioral, and social needs.

An organized service delivery system has the potential to better identify individuals' needs and provide accountability to meet those needs. However, health care and LTSS leadership at the state and federal level must ensure that people's core needs are at the center of the system.

- **Develop person-centered assessment processes:** Expand current health assessment processes to include a functional assessment in order to provide a more complete picture on which to develop a plan to address an individual's medical and non-medical needs.

Additionally, states should develop a universal assessment tool for individuals using Medicaid-funded LTSS to provide 1) reliable and person-centered information to facilitate better care coordination; 2) consistent information with which to evaluate population level needs; and 3) widespread data to inform the development of HCBS quality measures.

- **Recognize and support the role of family caregivers:** Unpaid family caregivers often shoulder the primary responsibility of coordinating care for their loved ones. State and federal leadership must acknowledge the importance of family caregivers, and develop strategies to support their efforts. This could include assessments with specific caregiver questions so that providers can inform them about available resources. Many states have also established legal and system supports for family caregivers in addition to existing federal policies.

- **Increase affordability of LTSS:** Seven in ten Americans will need long-term care at some point in their lives, but the costs far exceed most people's resources. Developing financing options to make LTSS affordable for working families must be a priority so that Americans can access services to meet their evolving needs while aging with dignity, choice and independence.

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