Navigating the Uncertainties of our Health Care System: The Case Manager’s Role in the Affordable Care Act

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Objectives

• Describe the basic tenets of the Affordable Care Act (ACA) and how this may impact Michigan residents
• Identify changes in the American Health Care System due to the ACA
• Explain care coordination/case management role specifics that are integral in the evolving Health Care System
Affordable Care Act

March 2010

Accountability

Ensure Medicare Solvency

Accessibility

Quality
Political Challenges

It's the Law

Funding

Supreme Court

Medicare Solvency
Improving Accessibility

- Expanding Eligibility
- Funding
- Providers
- CMI
Improving Accountability

- Fraud Identification
- Facility Disclosure
- Regulate Insurers
- Outcome Driven
Improving Quality

- Promoting Partnerships
- Prevention & Education
- Management of Chronicity
- Care Coordination
Medicare Solvency

Fraud Reduction

Reform Delivery System

Modernize Financing Systems

Improve Quality (CMI)
Center for Medicare Innovation (CMI)

- Stimulate Creativity
- Improve Quality
- Streamline Innovation
- Control Costs
- Continuity of Care
- Demonstration Projects
- Pilot Programs
Medicare Changes

Donut Hole

Screenings

Medication Therapy Management
Preventative Care Benefits

Yearly Wellness Visit

Preventative screenings for diabetes and certain cancers (mammograms, colonoscopies, etc.)
Donut Hole – Patched (eventually)
ACA and Nursing Home Care

- More protections from abuse
  - Information regarding nursing homes, # of complaints and violations, etc. available
  - Each state must have a comprehensive nursing home website with information
    - http://www.michigan.gov/lara/0,1607,7-154-27417_27863-47315--,00.html
  - Additional information with links to state nursing home websites are available on the CMS website: Nursing Home Compare
  - Easier to file complaints and get resolution to complaints
Medication Therapy Management

Required – Plan D Providers

At Risk Individuals

Annual Review

Identify Potential Adverse Reactions

Must Provide a “Take Away”
Medicare Advantage Changes

- 1,600 Choices in Plans
- 10 Million Enrolled Now
- 13% More = 14,000,000,000 over next 5 years
- Extra Benefits – so more attractive
- $1,138 per Member-13% higher than regular Medicare
Medicare Advantage Overhaul

- 2011 Payments Frozen
- 2012 Cuts 12% Annually
- Cuts Avoided with Excellence
Medicare Advantage Overhaul

- Obtaining Excellent Status
- Receive Bonus
- Quality Initiatives
- Care Coordination
Medicare Advantage Overhaul

- Cannot charge more than regular Medicare for certain services such as chemo, kidney dialysis and skilled nursing care
- Starting in 2012, Medicare will begin to lower subsidies so that Advantage is more in line with regular Medicare (could result in a drop in extra services such as gym memberships, eyeglasses, etc.)
- Starting in 2014, must limit how much is spent on administrative costs
2010 ACA Changes

- Prohibits denying coverage of children with pre-existing conditions
- Prohibits insurance companies from rescinding coverage
- Eliminating Lifetime Limits on Insurance Coverage
- Appealing Insurance Company Decisions
- Establishing Consumer Assistance Programs in the States
- Offering Relief for 4 Million Seniors Who Hit the Medicare Prescription Drug “Donut Hole.”
2010 ACA Changes

- Providing Free Preventive Care
- Cracking Down on Health Care Fraud
- Providing Access to Insurance for Uninsured Americans with Pre-Existing Conditions
- Extending Coverage for Young Adults
- Allowing States to Cover More People on Medicaid
- Increasing Payments for Rural Health Care Providers
Offering Prescription Drug Discounts
Providing Free Preventive Care for Seniors
Improving Care for Seniors After They Leave the Hospital
Improving Health Care Quality and Efficiency
Increasing Access to Services at Home and in the Community
Bringing Down Health Care Premiums
Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage
2012 ACA Changes

- Linking Payment to Quality Outcomes
- Encouraging Integrated Health Systems
- Reducing Paperwork and Administrative Costs
- Understanding and Fighting Health Disparities
- Providing New, Voluntary Options for Long-Term Care Insurance (this part of the law most likely will not be implemented)
2013 ACA Changes

- Improving Preventive Health Coverage
- Expanding Authority to Bundle Payments
- Increasing Medicaid Payments for Primary Care Doctors
- Providing Additional Funding for the Children’s Health Insurance Program (CHIP)
2014 ACA Changes

- Prohibiting Discrimination Due to Pre-Existing Conditions or Gender
- Eliminating Annual Limits on Insurance Coverage
- Ensuring Coverage for Individuals Participating in Clinical Trials
- Establishing Affordable Insurance Exchanges
- Increasing the Small Business Tax Credit
- Increasing Access to Medicaid
- Promoting Individual Responsibility & assuring free choice
2015 ACA Changes

- Paying Physicians Based on Value Not Volume
Since the MI legislature did not act on MI Health Exchanges, MI will have to use the Federal Government’s Health Exchanges in 2014.

Michigan has received $22.8 million in grants from the Prevention and Public Health Fund

Health centers in Michigan have received $69.5 million to create new health center sites in medically underserved areas

$1.4 million to train health care aides

$1.8 million to expand PA programs

$4.4 million for school-based health centers

$7.7 million for maternal, infant, early childhood home visiting programs
The Evolution of our Health Care System

- Medical Home Model
- Accountable Care Organizations
- Medicare Community-Based Transitions Program
- Medicare Independence at Home Program
- Medicare Payment Bundling
- Money Follows the Person Program
- Balancing Incentives Program
- Medicaid Expansion
Medical Home Model

- Patient & family centered with full scope of care
- Coordinated, team-based care
- Community linkages with transition services
- Medication coordination & management
- EHR support
- Quality driven & evidence-based
- Integrated case management
Creating “teams” and eliminating “turfs”
Team approach to chronic disease care management
Michigan has one of the nation’s largest patient-centered medical home programs.
Through BCBS of MI patient-centered medical home program, 2,546 primary care providers in 774 practices achieved the designation of patient-centered medical home in 2011.
Accountable Care Organizations (ACOs)

- ACOs are an integrated provider approach to more efficient and effective delivery of care
- An ACO is a local health care organization & a related group of providers (hospitals, physicians)
- ACO can be a single, wholly owned organization or may be independent providers contractually related
- ACO includes health services across the continuum, from primary care, specialty care, acute care and long term care
- In the new law, an ACO would agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.
- HHS estimates that ACOs could save Medicare up to $940 million in the first four years
In Medicare’s traditional fee–for–service payment system, doctors and hospitals generally are paid more when they do more test and more procedures. This practice drives up costs. ACOs wouldn’t do away with fee for service but would create savings incentives by offering bonuses when providers keep costs down. Physicians and hospitals would have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases. Bottom line is providers would get paid more for keeping their patients healthy and out of the hospital (Kaiser Website).
Embedded case managers in the ACO organization responsible for facilitating communication between providers as well as multiple care coordination requirements such as measures related to medication reconciliation and issues relating to transitions of care. Major purpose is to assist with ACO reaching quality measures.
The Community–based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program (CMS Website).
CCTP Case Management Opportunities

- From hospital to home
- Community-Based Organizations
- High Risk Beneficiaries
- Medically Underserved Populations
Under the Independence at Home Demonstration, the CMS Innovation Center will work with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so improves care for Medicare beneficiaries with multiple chronic conditions. Additionally, the Demonstration will reward health care providers that provide high quality care while reducing costs (CMS Website)
Case Management Opportunities

- Visiting Physicians Association, P.C. – Flint/Saginaw/Marysville (Flint, Michigan)

- Visiting Physicians Association, P.C. – Lansing/Ann Arbor (Okemos, Michigan)
Under the Bundled Payments initiative, CMS would link payments for multiple services patients receive during an episode of care. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together (CMS Website).
Money Follows The Person Program

Extended - 2016

42 States +
Community First Choice (CFC)

- Transitioning from Institutional Care
- Person-Centered Plans
- Available October 2011
- 3.7 Billion for Next 3 Years
- Federal Matching – 6% to states
Community First Choice (CFC)

- Implementation Councils
- Assisted Living an Option
- Pays For Transition
- Pays for ADL’s (activities of daily living)
Eligible adults who meet income & asset criteria can receive Medicaid-covered services like those provided by nursing homes but can stay in their own homes. Examples of services: homemaker, respite, adult day care, transportation, chore services, counseling, personal emergency response system, personal care supervision.
Case Management Opportunities

- Many opportunities for care coordination in Community First Choice/and or the Waiver Program. Case management can facilitate appropriate transitions of care, medication reconciliation & other programs to assist the eligible adults to be able to receive the most appropriate level of care and to live at home as long as safety can be maintained.
The Balancing Incentive Program authorizes grants to States to increase access to non-institutional long-term services and supports (LTSS) as of October 1, 2011.

The Balancing Incentive Program will help States transform their long-term care systems by:
- Lowering costs through improved systems performance & efficiency
- Creating tools to help consumers with care planning & assessment
- Improving quality measurement & oversight
Case Management Opportunities

- Care coordination can facilitate eligible individuals to receive appropriate home & community-based services to avoid unnecessary long term care services in nursing homes.
2010 State Awards

Implementing the Affordable Care Act – 2010 State Awards

The Administration on Aging and the Centers for Medicare & Medicaid Services

Map of the United States indicating states with different categories for the Affordable Care Act in 2010:

- Part A: MIPPA Funding
- Part B: Options Counseling
- Part C: Money Follows the Person
- Part D: Evidence Based Care Transitions

States with circles in green indicate application for Part A.
States with circles in orange indicate application for Part B.
States with circles in yellow indicate application for Part C.
States with circles in red indicate application for Part D.

Legend:
- American Samoa
- Guam
- N. Marianas Islands
- Puerto Rico
- Virgin Islands
The Affordable Care Act actually refers to two separate pieces of legislation — the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 — that, together expand Medicaid coverage to millions of low-income Americans and makes numerous improvements to both Medicaid and the Children’s Health Insurance Program (CHIP).

(CMS Website)
Coverage for the newly eligible adults will be fully funded by the federal government for three years, beginning in 2014, phasing down to 90% by 2020. Authorization for the Children's Health Insurance Program (CHIP) is extended through 2019 and funding is currently authorized through 2015. Additional federal funding for state Medicaid programs is also available for primary care, preventive care, community based long-term services and supports, and new demonstrations to improve quality and re-engineer delivery systems (CMS Website).
In 2012, the Supreme Court ruled that states could “opt out” of participating in the Medicaid expansion.

"We are concerned many states will choose not to expand coverage," Bruce Siegel, president of the National Association of Public Hospitals and Health Systems, said in a statement released following the court's decision. "In the 26 states that participated in the federal lawsuit, more than 27 million people have no insurance," he added, and many of those who would have been eligible for Medicaid in 2014 "might no longer have that option."
Expanded Medicaid in MI would add at least 400,000 individuals to the federal-state health insurance program for the poor and disabled.

At this point, MI is participating in the expansion. However Governor Snyder has said he is watching costs associated with the expansion closely.

States can rescind expansion at any time with no penalty other than loss of federal funds.
Case Management in the Health Care System of the Future

- Embedded in larger physician offices, ACOs, MCOs, Medicare Advantage, Medicaid, etc.
- Care coordination will facilitate the “de-fragmenting” of our health care system.
- “Turf” battles will go away and be replaced by “teams” whose purpose is to provide integrated care to improve quality and reduce the costs of health care. Care coordination will be the central pillar in this team.
- It is time for us to carpe diem (seize the day)!
Available Resources/References

- AARP (www.aarp.org/health/health-care-reform)
- Healthcare.gov Website
- CMS Website
- Kaiser Website
- Michuhcan Website
- MI Department of Community Health (http://www.michigan.gov/mdch/)
- The Bottom Line: How the Affordable Care Act Helps Michigan Families (www.familiesusa.org)