Health Reform Impacts and Improvements Affecting Medicare Beneficiaries

Bob Jackson

Without a doubt, Medicare has been a huge success and has provided a strong health care package for those eligible for coverage. It is impossible and unreasonable to go back and say we should have done it all differently. Over the decades, since its adoption in 1965, benefits have been added, eliminated, enhanced, and weakened—and still overall costs have risen steadily. For years, Medicare has been a political football caught in the middle of the entitlement debate. And make no mistake; it will continue to be a focus of attention as the costs of care rise and the solvency of the trust funds continue to be threatened.

While the new Patient Protection and Affordable Care Act (PPACA) takes considerable steps to enhance Medicare benefits and address long-term solvency, the system’s costs and needs remain great. This bill solves only part of the projected costs and needs. This commentary focuses on those Medicare enhancements, including issues of costs and controls, fraud and abuse, prescription coverage, prevention services, long-term care, Medicaid, and workforce development.

There are many ways to control costs. Those addressed by the PPACA are designed to keep Medicare financially stable for almost a decade longer than if no law had been passed. Some of those cost containment strategies include:

- A new Independent Payment Advisory Board (IPAB) that will examine extending Medicare solvency, slowing cost growth, improving quality, and identifying waste throughout the health care system to help hold down costs for people in Medicare and for those not yet eligible, while seeking to reduce the deficit. The IPAB must meet various spending targets in the second 10 years of its existence, and the AARP (among other groups) is concerned about the unintended impact these savings might have on beneficiaries’ access to or quality of care.
- An adjustment to Medicare Advantage (MA) reimbursements that will be phased in over the next seven years. Since 2003 and the passage of the Medicare Modernization Act, MA plans have been reimbursed at an average of 14% more than traditional fee-for-service Medicare. Over the first seven years of the PPACA, payments to MA plans will be reduced incrementally until they are paid the same as traditional Medicare. At the same time, MA plans will be eligible for performance bonuses to reflect differences in quality and geographic location.

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- Increased funding to fight waste, fraud, and abuse in Medicare and the rest of the health care system by providing additional prosecutors as well as computer system enhancements to catch perpetrators more quickly.
- A new Community-Based Care Transitions Program to provide care transition services to high-risk Medicare beneficiaries to help ensure smooth transitions to home or other settings after a hospital discharge and reduce unnecessary re-hospitalizations.

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There are several benefit enhancements designed to provide better care at a lower cost. Two critical improvements include dramatic changes to Medicare Part D and the adding of critical preventive services. In 2003 the Medicare Prescription Drug, Improvement, and Modernization Act created Medicare Part D, the new prescription package for Medicare beneficiaries. From the beginning, the structure of that plan was attacked, and the new reform package addresses a significant gap in the Part D benefits.

The infamous coverage gap or “doughnut hole” will be remedied in several ways. In 2010, a Part D enrollee who enters the doughnut hole will receive a one-time rebate of $250. Beginning in 2011, the PPACA will provide 50% discounts for brand-name drugs and biologics for enrollees while they are in the doughnut hole. Also beginning in 2011, the coverage gap will begin to close so that by 2020 it will be gone entirely and beneficiaries will only be responsible for 25% of their prescription drug costs (both brand and generic) from the time they enter the initial coverage period (i.e., after meeting their deductible) to the time they enter catastrophic coverage at which point they are responsible for 5% of their drug costs. Importantly, the law adjusts the indexing of the out-of-pocket threshold (i.e., the point where enrollees enter catastrophic coverage) between 2014 and 2019 to help slow its growth.

Additionally, the PPACA will improve guaranteed Medicare benefits by adding free preventive services (with no copayments or deductibles) for such procedures as colonoscopies, mammograms, bone density screenings, and annual check-ups. Also, payments will be improved for doctors and hospitals in rural communities, and payments for primary care physicians will be enhanced by 10%.

A number of new long-term care and Medicaid benefits and enhancements are being introduced, including:

- The Community Living Assistance Services and Supports (CLASS) Act, which is a national self-sustaining, voluntary, payroll deduction-based insurance program beginning in 2011 to help individuals pay for services and supports that will help them live independently in their homes and communities.
- An enhanced federal Medicaid match for states if they provide home- and community-based attendant services and supports to individuals eligible for institutional care under Medicaid. There are additional incentives to states for expanding home- and community-based services, and the Money Follows the Person Rebalancing Demonstration grants will continue for five more years through 2016.
- The rate at which Medicaid reimburses primary care providers will be increased to the Medicare rate in 2013 and 2014 in those states that do not already do so.

Regarding the training of geriatricians and direct care workers, Medicare has traditionally only paid for the training of physicians (approximately $8 billion per year) and of diploma-level nursing programs (approximately $150 million per year). With PPACA, the first opportunity for funding graduate-level nursing education will be the Medicare Graduate Nursing Education (GNE) Demonstration Program. This four-year program is funded at $200 million and is available for hospitals that partner with nursing schools and community-based health clinics to increase the number of advanced practice registered nurses who can provide primary care, chronic care management, women's health care, and pain management to Medicare beneficiaries and their families.

In addition to ongoing Medicare funding for physicians and for the GNE Demonstration Program, the PPACA has authorized funding for other education and training programs to help bolster the health care workforce to provide care for the additional 32 million Americans who will be newly covered. The PPACA has authorized $338 million (almost $100 million more than FY 2010 funding) for nursing education scholarships and loans to help increase the number of nurses and nursing faculty who can teach the influx of nursing students. The PPACA has also created a mandatory $7 billion fund for community health centers and directed another $1.5 billion in guaranteed funding for the National Health Service Corps to recruit more physicians and nurses to provide health care in community health centers that are located in health professional shortage areas. This $1.5 billion will go toward scholarships for medical and nursing students who commit to providing two to four years of service in these critical areas. It also provides loan repayment programs for physicians and nurses who serve in these areas.

Another important workforce item related to Medicare is the PPACA-awarded grants to up to six states to conduct three-year demonstration projects to develop core training competencies and certification programs for personal or home care aides. PPACA appropriates $5 million for each FY 2010-2012 to be used for the personal or home care aide training demonstrations.

Several other workforce programs were authorized by PPACA but not funded. They include:

- Grants to entities (educational institutions in partnership with long-term care providers) to provide new training opportunities for direct care workers in long-term care settings. Funds are to be used to provide assistance to workers to offset the costs of tuition and fees.
- Grants of $150,000 to not more than 24 geriatric education centers to offer a fellowship program with short-term intensive courses on geriatrics, chronic care management, and long-term care for medical school faculty and other health professions schools. In addition, the grantee must offer either family caregiver and direct care provider training (at no or nominal cost to enrollees) or develop best practice materials on mental disorders,
medication safety, and management of dementia among older adults.

- Grants to advanced practice nursing, clinical social work, pharmacy, or psychology students who are pursuing a doctorate or other advanced degree in geriatrics who agree to teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of five years. It also expands the scope of individuals eligible for geriatric academic career awards to include health professionals with junior faculty appointments in accredited health professions schools.

- Expands the Comprehensive Geriatric Education grants to educational institutions that establish traineeships for individuals who are preparing for advanced education in geriatric nursing, long-term care, geropsychiatric nursing, or other nursing areas that specialize in care of the elderly.

These new and enhanced benefits to Medicare are designed to improve care through prevention, quality incentives, and improved access; adjust reimbursements to health care providers; amend some benefits; cut overall costs; and extend the solvency of Medicare. It was a hard fought battle to finalize these provisions and the final regulations guiding the implementation will be closely monitored. We all are part of the system and are a critical part of the solution. NCMJ