

Provisions Relevant to Aging Services Technologies
HEALTH CARE REFORM BILL (H.R. 3590)
“PATIENT PROTECTION AND AFFORDABLE CARE ACT”

As Signed into Law March 23, 2010

1). Certified EHR Grant Program for Long-term Care Facilities

The Act contains a \$67.5 million grant program for long-term care facilities over four years beginning in FY 2011. The grants are to be used to offset costs related to purchasing, leasing, developing, and implementing certified EHR technology and may be used for any computer infrastructure including hardware and software, upgrading current systems, and staff training. LTC facilities that receive grants are required to participate in state-level health information exchange activities where available. The HHS Secretary is required to adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature.

Bill Language:

PART II--PROGRAMS TO PROMOTE ELDER JUSTICE

`SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

`(b) Certified EHR Technology Grant Program-

`(1) GRANTS AUTHORIZED- The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

`(2) USE OF GRANT FUNDS- Funds provided under grants under this subsection may be used for any of the following:

`(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

`(B) Making improvements to existing computer software and hardware.

`(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

`(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

`(3) APPLICATION-

`(A) IN GENERAL- To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

`(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS- Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

“(4) PARTICIPATION IN STATE HEALTH EXCHANGES.—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 3013(f) of the Public Health Service Act) under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

“(5) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

`(c) Adoption of Standards for Transactions Involving Clinical Data by Long-Term Care Facilities-

`(1) STANDARDS AND COMPATIBILITY- The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D-4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

`(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY-

`(A) IN GENERAL- Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

`(B) RULE OF CONSTRUCTION- Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

`(3) REGULATIONS- The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

`(d) Authorization of Appropriations- There are authorized to be appropriated to carry out this section--

`(1) for fiscal year 2011, \$20,000,000;

`(2) for fiscal year 2012, \$17,500,000; and

`(3) for each of fiscal years 2013 and 2014, \$15,000,000.

2). *Demonstration Project for Use of HIT in Nursing Homes*

The Act authorizes an unspecified amount of funding to conduct a demonstration project to develop best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care. One or more competitive grants are to be implemented by March 2011 for not more than three years.

Bill Language:

SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) **IN GENERAL.**—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) **CONDUCT OF DEMONSTRATION PROJECTS.**—

(1) **GRANT AWARD.**—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) **CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.**—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) **DURATION AND IMPLEMENTATION.**—

(1) **DURATION.**—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) **IMPLEMENTATION.**—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) **DEFINITIONS.**—In this section:

(1) **NURSING FACILITY.**—The term “nursing facility” has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(3) **SKILLED NURSING FACILITY.**—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(e) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(f) **REPORT.**—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

3) *Requires the Secretary, in consultation with stakeholders (including representatives of nursing facilities) to develop specifications for Medicare Part D prescription drug plans (“PDPs”) to reduce pharmacy waste in LTC facilities using uniform techniques that will be determined in the analysis process*

Bill Language:

SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) **IN GENERAL.**—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

“(3) **REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.**—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or **automated dose dispensing**, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.’’.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

4). New Models of Care Utilizing Technology:

I. The “Community Living Assistance Services and Supports Act” (CLASS) Act

A primary AAHSA priority in the health care reform bill, the CLASS Act will enable a new model of funding for long-term services and supports, including the use of aging services technologies to meet care needs.

Bill Language (excerpts):

“(c) **PAYMENT OF BENEFITS.**—

“(1) **LIFE INDEPENDENCE ACCOUNT.**—

“(A) **IN GENERAL.**—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

“(B) **USE OF CASH BENEFITS.**—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support.

II. Use of Technology in New Cost Efficient Payment Models – Center for Medicare and Medicaid Innovation

The Act establishes the Center for Medicare and Medicaid Innovation within CMS. One of the Center's programs will be to develop new funding mechanisms with costs savings by better coordinating and managing care through newly established "accountable care organizations" (ACOs). One of the methodologies available to ACOs will be "the use of telehealth, remote patient monitoring, and other such enabling technologies."

Bill Language (excerpts):

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

“(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the ‘CMI’) to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).“(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011. APPLICABLE INDIVIDUAL.—The term ‘applicable individual’ means—“(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;“(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or“(iii) an individual who meets the criteria of both clauses (i) and (ii).

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section: “SHARED SAVINGS PROGRAM “SEC. 1899. (a) ESTABLISHMENT.—“(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the ‘program’) that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—“(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ‘ACO’);“(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.”

III. Use of HIT in Health Homes for Enrollees with Chronic Conditions

The Act authorizes states to develop a new method of providing home care for enrollees with chronic conditions. Through the use of teams of health care providers this option allows states to provide a “health home” model for such individuals. It requires participating states to include in their state plan amendment a proposal for use of health information technology in providing health home services and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

Bill Language (excerpts):

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) State Plan Amendment- Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

“Sec. 1945. State Option to Provide Coordinated Care Through a Health Home for Individuals With Chronic Conditions-

“(a) In General- Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

“(b) Health Home Qualification Standards- The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

“(c) Payments-

“(1) IN GENERAL- A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

“(2) METHODOLOGY-

“(A) IN GENERAL- The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment--

“(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

“(ii) shall be established consistent with section 1902(a)(30)(A).

`(B) ALTERNATE MODELS OF PAYMENT- The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

`(3) PLANNING GRANTS-

`(A) IN GENERAL- Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

`(B) STATE CONTRIBUTION- A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111-5) for each fiscal year for which the grant is awarded.

`(C) LIMITATION- The total amount of payments made to States under this paragraph shall not exceed \$25,000,000.

`(f) Monitoring- A State shall include in the State plan amendment--

`(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

`(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

`(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS-

`(A) IN GENERAL- Subject to subparagraph (B), the term `eligible individual with chronic conditions' means an individual who--

`(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

`(ii) has at least--

`(I) 2 chronic conditions;

`(II) 1 chronic condition and is at risk of having a second chronic condition; or

`(III) 1 serious and persistent mental health condition.

`(B) RULE OF CONSTRUCTION- Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

`(2) CHRONIC CONDITION- The term `chronic condition' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

`(A) A mental health condition.

`(B) Substance use disorder.

`(C) Asthma.

`(D) Diabetes.

`(E) Heart disease.

`(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

`(3) HEALTH HOME- The term `health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

`(4) HEALTH HOME SERVICES-

`(A) IN GENERAL- The term `health home services' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

`(B) SERVICES DESCRIBED- The services described in this subparagraph are--

`(i) comprehensive care management;

`(ii) care coordination and health promotion;

`(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

`(iv) patient and family support (including authorized representatives);

`(v) referral to community and social support services, if relevant; and

`(vi) use of health information technology to link services, as feasible and appropriate.

`(5) DESIGNATED PROVIDER- The term `designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic--

`(A) has the systems and infrastructure in place to provide health home services; and

`(B) satisfies the qualification standards established by the Secretary under subsection (b).

`(6) TEAM OF HEALTH CARE PROFESSIONALS- The term `team of health care professionals' means a team of health professionals (as described in the State plan amendment) that may--

`(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

`(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

`(7) HEALTH TEAM- The term `health team' has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.'

IV. Use of Technology in New State Options for Long-Term Services and Supports

The Act provides States with new state plan options for providing long-term services and supports, including a “community first choice option” for home and community-based attendant care services. Under this option, states could utilize technologies to ensure continuity of services and supports. The exact types of technologies permissible will need to be clarified, as the language prohibits reimbursement for “assistive technology devices and services” but allows “beepers and other electronic devices” as well as expenditures that “substitute for human assistance.”

Bill Language (excerpts):

Subtitle E—New Options for States to Provide Long-Term Services and Supports

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

“(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY BASED ATTENDANT SERVICES AND SUPPORTS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

“(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

“(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual’s representative;

“(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

“(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

“(iv) the furnishing of which—

“(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual’s representative; “

(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual’s representative, regardless of who may act as the employer of record; and

“(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

“(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

“(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

“(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

“(iii) voluntary training on how to select, manage, and dismiss attendants.

“(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

“(i) room and board costs for the individual;

“(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

“(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

“(iv) medical supplies and equipment; or

“(v) home modifications.

“(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

“(i) expenditures for transition costs such as rent and utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

“(ii) expenditures relating to a need identified in an individual’s person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.