Florida Association of Aging Services Providers e-Newsletter

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Guest Editor: Ginna O'Connor, Senior Resource Association

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Senior Resource Association
Providing activities, education and services

Message from the President

by John Clark, Council on Aging of West Florida, Inc.

A Special Thank You

A friend of mine once said that you can never say thank you too often. Truer words were never spoken. The truth is, for most of us, we don't say it enough to those who have earned it, who deserve it and who need it; but usually don't really seek it. Now there are lots of reasons why we thank people; most often it is because they have done something for which we are personally grateful.

During this holiday season which means so much to people from many religious faiths, I want to extend, on behalf of the Florida Association of Aging Services Providers, my deepest thanks to those who often form the ***backbone*** of our agency's programs and services---caregivers. What we do through our many programs and services would not, in a great many cases, be successful, or possible, were it not for the caregivers of our program recipients. In most cases these caregivers are family members who sacrifice much for those they love. However, there is often a "hidden cost" to caregiving.

It is a fact that family caregivers are more likely than non-caregivers to experience symptoms of depression or anxiety. According to the Alzheimer's Association, 30-40% of dementia caregivers suffer from depression and emotional stress. Family caregivers experiencing extreme stress have been shown to age prematurely. This level of stress can take as much as 10 years off a family caregiver's life (Arno, Peter S., "Economic Value of Informal Caregiving"). We also know that American businesses can lose as much as $34 billion each year due to employees' need to care for loved ones 50 years of age and older (MetLife Mature Institute and National Alliance for Caregiving).

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FASP Newsletter Editorial

Ginna O'Connor, Senior Resource Association, Guest Editor

As 2012 draws to a close, I find it impossible not to reflect upon policy issues that dominated our public discourse this year - particularly health care. Considering that we have the most expensive health care system in the world, and that one in six Americans do not have health insurance, health care is truly an issue that impacts us all. In my own community of Indian River County, I was surprised to find that based on a telephone survey of 450 individuals age 50+ conducted in April, their greatest concern is health care and health insurance. Even those benefitting from Medicare ranked health care over transportation and economic-related issues!

With the combination of the U.S. Supreme Court's decision and President Obama's re-election, the implementation of the Affordable Care Act (ACA) is solidly moving forward. ACA represents the most important regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965, and its implications are deeply contested. Although ACA requires states to expand Medicaid to cover more individuals beginning in 2014, many are touting the dangers of expanding access without addressing costs. Invariably, states may look to restrict health care plans, such as limiting the number of medications patients can receive, the brands they can purchase and their physicians. It is imperative that the Aging Network keep abreast of ACA's execution, and be prepared to advocate for our elders.

As a home and community based service provider, I've felt that my biggest challenge with the Affordable Care Act has been to discern fact from assumptions, rumors and opinion. With this in mind, enclosed you will find an ACA Implementation Timeline which includes a summary of each provision. As I reviewed it, I was both impressed and overwhelmed by the breadth of the legislation, and grateful to finally see an unbiased comprehensive summary. I want to thank Colette Vallee and Barbara Denmark from the FASP Management Staff for condensing this immense piece of legislation. We hope the Implementation Timeline will serve as a valuable resource for you and your staff.

On behalf of the Board and Management Staff of the Florida Association of Aging Services Providers, we wish you and yours a merry holiday season!

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We also know that children of aging parents often make changes in their work life to accommodate caregiving responsibilities (MetLife Mature Market Institute). In 2006 during a symposium at the Department of Veterans' Affairs it was estimated that this "free" caregiving was worth some $306 billion. Compare that to the $158 billion spent on nursing home and homecare services. Clearly, caregiving is a "bargain" for our state and our nation. Caregivers deserve special thanks from ALL Americans.

But you know it is also true that in both large and small ways, we have special people who are caregivers who fall into categories other than a direct family member. We have volunteers who build wheelchairs ramps and deliver meals; these too are caregivers who are providing special care and assistance to those they may have never met. We have caregivers who are case managers, congregate meal site managers, homemakers and personal care workers. These "paid" caregivers are also special people delivering care to those who are often vulnerable and in need of special care and assistance. And you all know, as well as I do, that they are clearly not in it for the "money."

So, join me in wishing all our caregivers a most happy holiday season as we extend our deepest thanks to all of them, because, whether a family caregiver, an informal volunteer caregiver or a paid caregiver; they are all deserving of our deepest gratitude. Not "just" because they save us all money, but because they are truly the unsung heroes of the service delivery system in our local communities, in Florida and the nation.

Sincerely,
John Clark

The Nursing Home Reform Law Turns 25

On December 22, 1987 President Ronald Reagan signed into law the first major revision of the federal standards for nursing home care since the 1965 creation of Medicare and Medicaid. Passed as part of the Omnibus Reconciliation Act of 1987 (OBRA 87), the Nursing Home Reform Law forever changed our nation's legal expectations of how nursing homes provide care and services. The law focuses on quality of care and quality of life outcomes for every individual resident and emphasizes that one's rights do not disappear when they live in a nursing home. The Nursing Home Reform Law is visionary in its insistence on person-centered planning and services, requiring nursing homes to provide services to "attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident."

Twenty-five years ago, Long-Term Care Ombudsman Programs and Citizen Advocacy Organizations provided the grass-roots stories about the nursing home residents' experiences that served as a catalyst for change and inspired these new standards. Today, Long-Term Care Ombudsman Programs continue to promote full implementation of the Nursing Home Reform Law by supporting every resident's ability to make choices about their daily life and care. Dedicated staff and volunteer ombudsmen across the nation work to resolve individual resident complaints, promote resident interests in public policy, and serve as a resource to residents, their families and facility staff.

Click for more information - History of the Nursing Home Reform Law

AARP Florida 2013 Legislative Priorities

1. Health and Supportive Services:

Expanded Medicaid eligibility:

The federal Affordable Care Act proposes and funds for several years expansion of Medicaid eligibility to those with incomes up to 133%of the federal poverty level. Florida should accept the increased federal funding and promote/provide affordable health care services to these underinsured/uninsured Florida residents.

Nursing Home Staffing:

AARP urges the Legislature to reinstate the Nursing Home Staffing Levels to 3.9 hours of direct nursing care/ resident/per day. Florida should permanently keep the "NURSING" in Nursing Homes.

In 2011, the Legislature reduced the required "minimum" weekly "average" nursing home staffing levels by nearly eight percent.

A 2011 Florida study found that with every 6 minute increase (tenth of an hour) in CNA HPRD, there is a 3% reduction in the nursing home quality of care deficiency score.

Assisted Living Facilities:

In 2010, a Miami Herald exposé highlighted cases of abuse, harm and neglect that have occurred in Florida Assisted Living Facilities, which AARP finds to be completely unacceptable. There should be preventive measures in place, such as increased training and credentialing for ALF staff and administrators and enhanced regulatory authority over ALF operations.

Home and Community Based Services(HCBS):

AARP is a great proponent of the medical-home model. This bottom-up model is one that the Legislature should look at in the event that Medicaid reform needs to be re-visited. If the current Medicaid Reform proposal moves forward, AARP urges the Legislature to devote a greater share of Medicaid funding and other revenue to HCBS. Likewise the Legislature should devote a greater portion of other aging program resources and general revenue to HCBS. Floridians prefer to age in their homes and communities.

2. Consumer matters:

Utilities:

Florida needs a renewable energy policy. However, the Legislature should frown upon or, at least, critically examine requests for market carve-outs for types of renewable energy and for their producers. Energy producers should bear the risks for development costs. Customers should pay for consumption of the energy products. The Legislature should revisit the nuclear cost recovery statute. Utilities are collecting millions of dollars from consumers for plants that may never be built.

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Fraud and Deceptive Practices:

Florida should beef-up consumer protections against perpetrators of fraud and deceptive acts and practices, particularly those directed at the elderly, whom scam artists too often target.

Public safety:

Florida should strengthen protections for safe drivers, passengers and pedestrians on Florida's public byways (e.g., by educating the public re: distractions while driving or walking and by placing significant restrictions/ prohibitions on distracted driving/walking).

State Revenue:

Florida has a constitutional requirement to balance its annual budget. Increasing demand and need for state services warrants further action by the Legislature to provide Florida an adequate, but affordable, revenue stream to fund services. AARP urges the Legislature to join with the state's business community and AARP in support of collection of taxes on Internet and other forms of remote retail transactions.

Department of Elder Affairs

The Department has filled the Nutrition Program Manager position vacated in August 2012 by Holly Greuling. The new Nutrition Program Manager is Craig McCormick. Craig is a licensed and registered dietitian with experience in clinical nutrition.

Craig began working with the Department on October 15, 2012 and has been learning about the programs in the Unit. He is excited about the opportunity to work with the Department and the aging network. Please welcome him, mccormickc@elderaffairs.org

PUBLIC WORKFORCE: Exit Strategy

Special Series: The mass exodus of baby boomers from the workforce has been a crisis in the making for years. The Great Recession pushed planning to the backburner and left many in the public sector ill-prepared.

A little more than a decade ago, a report by the Pew Research Center's Internet & American Life Project coined the now well known phrase "silver tsunami." The report looked at the potential impact of the approaching retirement of baby boomers -- a wave of retirements that was expected to crash on public- and private-sector shores in 2011, when the boomers began to turn 65. It was an event that was forecast to continue throughout most of the next decade, leaving in its wake an unprecedented shortage of skilled workers. Read more >>

MetLife Foundation Creativity and Aging in America Leadership Award

The MetLife Foundation Leadership Award recognizes three state-of-the-art programs in creativity and aging. Programs can take place in a variety of settings including: healthcare, arts institutions, or communities providing exemplary arts programming to the demographic they serve. There will be three Leadership Awards awarded annually, one in each of the following categories:

- Health and Wellness
- Lifelong Learning
- Community Building

The Winning Program will receive an award in the amount of $5,000 and a complementary one-year National Center for Creative Aging (NCCA) Organizational membership.

The application deadline is 5:00 PM EST January 4, 2013.

Applicants must be a current member of NCCA.

Click here for additional criteria and to download an application.

Medicaid Specific– Affordable Care Act

The Affordable Care Act provides Americans with better health security by putting in place comprehensive health insurance reforms that will:

- Expand coverage,
- Hold insurance companies accountable,
- Lower health care costs,
- Guarantee more choice, and enhance the quality of care for all Americans.

The Affordable Care Act actually refers to two separate pieces of legislation — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) — 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).

This section focuses on the major provisions of the Affordable Care Act related to Medicaid and CHIP. If you are interested in the law as a whole, you can:

Read the Compilation of the Affordable Care Act, or Review the law by section.

Since the new law was enacted in March 2010, CMS has worked together with state partners to identify key implementation priorities and provide the guidance needed to prepare for the significant changes to Medicaid and CHIP that will take effect on January 1, 2014. In particular, CMS has provided several forms of guidance and federal support for state efforts to develop new or upgrade existing eligibility systems.

In March 2012, CMS released two final rules defining the eligibility and enrollment policies needed to achieve a seamless system of coverage for individuals who will be eligible for Medicaid beginning in 2014, as well as eligibility and enrollment for the new Affordable Insurance Exchanges. The final rules establish the framework for States' implementation of the eligibility expansion going forward.

A specific description of all of the major Medicaid and CHIP-related provisions of the Affordable Care Act as well as related policy guidance can be found under ACA Provisions.

The Affordable Care Act Implementation Timeline

On March 23, 2010, President Obama signed the Affordable Care Act. The law expands health coverage and puts in place comprehensive health insurance reforms that will roll out over four years and beyond, with most changes taking place in 2014.

Other improvements are already in place. Use this timeline to learn about what's changing for Medicaid and the Children's Health Insurance Program (CHIP) and when.

This timeline includes major Medicaid provisions in the Affordable Care Act but does not include every change; the Healthcare.gov ACA timeline has information on other Affordable Care Act provisions.

For information on federal guidance that has been released related to Medicaid and CHIP, see ACA provisions. 2010 2011 2012 2013 2014 2015

Affordable Care Act Implementation Timeline

Here is an Affordable Care Act Implementation Timeline which includes a summary of each provision. FASP hopes this Implementation Timeline will serve as a valuable resource for you and your staff.

Provisions by Year

2010 Provisions

Review of Health Plan Premium Increases - Requires the federal government to create a process, in conjunction with states, where insurers have to justify unreasonable premium increases. Provides grants to states for reviewing premium increases.

Changes in Medicare Provider Rates - Reduces annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units and adjusts payments for productivity.

Qualifying Therapeutic Discovery Project Credit - Provides tax credits or grants to employers with 250 or fewer employees for up to 50% of the investments costs in projects that have the potential to produce new therapies, reduce long-term cost growth, or advance the goal of curing cancer within 30 years. The grant or tax is available for investments made in 2009 or 2010.

Medicaid and CHIP Payment Advisory Commission - Provides funding for and expands the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services in Medicaid.

Comparative Effectiveness Research - Establishes a non-profit Patient-Centered Outcomes Research Institute to conduct research that compares the clinical effectiveness of medical treatments.

Prevention and Public Health Fund - Appropriates $5 billion for fiscal years 2010 through 2014 and $2 billion for each subsequent fiscal year to support prevention and public health programs.

Medicare Beneficiary Drug Rebate - Provides a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010. Further subsidies and discounts that ultimately close the coverage gap begin in 2011.

Small Business Tax Credits - Provides tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees. Phase I (2010-2013): tax credit up to 35% (25% for non-profits) of employer cost; Phase II (2014 and later): tax credit up to 50% (35% for non-profits) of employer cost if purchased through an insurance Exchange for two years.

Medicaid Drug Rebate - Increases the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%) and to 13% of average manufacturer price for non-innovator, multiple source drugs. Extends the drug rebate to Medicaid managed care plans.

Coordinating Care for Dual Eligibles - Establishes the Federal Coordinated Health Care Office to improve care coordination for dual eligibles (people eligible for both Medicare and Medicaid).

Generic Biologic Drugs - Authorizes the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

New Requirements on Non-profit Hospitals - Imposes additional requirements on non-profit hospitals to conduct community needs assessments and develop a financial assistance policy and impose a tax of $50,000 per year for failure to meet these requirements.

Medicaid Coverage for Childless Adults - Creates a state option to provide Medicaid coverage to childless adults with incomes up to 133% of the federal poverty level. (States will be required to provide this coverage in 2014.)

Reinsurance Program for Retiree Coverage - Creates a temporary reinsurance program for employers provid-

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ing health insurance coverage to retirees over age 55 who are not eligible for Medicare.

Pre-existing Condition Insurance Plan - Creates a temporary program to provide health coverage to individuals with pre-existing medical conditions who have been uninsured for at least six months. The plan will be operated by the states or the federal government.

New Prevention Council - Creates the National Prevention, Health Promotion and Public Health Council to develop a national prevention, health promotion and public health strategy.

Consumer Website - Requires the Department of Health and Human Services to develop an internet website to help residents identify health coverage options.

Tax on Indoor Tanning Services - Imposes a tax of 10% on the amount paid for indoor tanning services.

Expansion of Drug Discount Program - Expands eligibility for the 340(B) drug discount program to sole-community hospitals, critical access hospitals, certain children's hospitals, and other entities. Implementation: Applications accepted beginning August 2, 2010.

Adult Dependent Coverage to Age 26 - Extends dependent coverage for adult children up to age 26 for all individual and group policies.

Consumer Protections in Insurance - Prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage, rescinding coverage except in cases of fraud, and from denying children coverage based on pre-existing medical conditions or from including pre-existing condition exclusions for children. Restricts annual limits on the dollar value of coverage (and eliminates annual limits in 2014)

Insurance Plan Appeals Process - Requires new health plans to implement an effective process for allowing consumers to appeal health plan decisions and requires new plans to establish an external review process.

Coverage of Preventive Benefits - Requires new health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

Health Centers and the National Health Service Corps - Permanently authorizes the federally qualified health centers and NHSC programs and increases funding for FQHCs and for the NHSC for fiscal years 2010-2015.

Health Care Workforce Commission - Establishes the National Health Care Workforce Commission to coordinate federal workforce activities and make recommendations on workforce goals and policies and establishes the National Center for Health Workforce Analysis to undertake state and regional workforce data collection and analysis.

Medicaid Community-Based Services - Provides states with new options for offering home and community-based services through a Medicaid state plan amendment to certain individuals and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

2011 Provisions

Minimum Medical Loss Ratio for Insurers - Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers if the share of the premium spent on clinical services and quality is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.

Closing the Medicare Drug Coverage Gap - Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begins phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
Medicare Payments for Primary Care - Provides a 10% Medicare bonus payment for primary care services; also, provides a 10% Medicare bonus payment to general surgeons practicing in health professional shortage areas.

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Medicare Prevention Benefits - Eliminates cost-sharing for Medicare-covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waives the Medicare deductible for colorectal cancer screening tests; authorizes Medicare coverage for a personalized prevention plan, including a comprehensive health risk assessment.

Center for Medicare and Medicaid Innovation - Creates the Center for Medicare and Medicaid Innovation to test new payment and delivery system models that reduce costs while maintaining or improving quality.

Medicare Premiums for Higher-Income Beneficiaries - Freezes the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels resulting in more people paying income-related premiums, and reduces the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.

Medicare Advantage Payment Changes - Restructures payments to private Medicare Advantage plans by phasing-in payments set at increasingly smaller percentages of Medicare fee-for-service rates; freezes 2011 payments at 2010 levels; and prohibits Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.

Medicaid Health Homes - Creates a new Medicaid state option to permit certain Medicaid enrollees to designate a provider as a health home and provides states taking up the option with 90% federal matching payments for two years for health home-related services.

Chronic Disease Prevention in Medicaid - Provides 3-year grants to states to develop programs to provide Medicaid enrollees with incentives to participate in comprehensive health lifestyle programs and meet certain health behavior targets.

National Quality Strategy - Requires the Secretary of the federal Department of Health and Human Services to develop and update annually a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

Changes to Tax-Free Savings Accounts - Excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a Health Reimbursement Account or health Flexible Spending Account and from being reimbursed on a tax-free basis through a Health Savings Account or Archer Medical Savings Account. Increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the amount used.

Grants to Establish Wellness Programs - Provides grants for up to five years to small employers that establish wellness programs. Implementation: Funding authorized beginning in fiscal year 2011.

Teaching Health Centers - Establishes Teaching Health Centers and provides payments for primary care residency programs in community-based ambulatory patient care centers.

Medical Malpractice Grants - Authorizes $50 million for five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Funding for Health Insurance Exchanges - Provides grants to states to begin planning for the establishment of American Health Benefit Exchanges and Small Business Health Options Program Exchanges, which facilitate the purchase of insurance by individuals and small employers.

Nutritional Labeling - Requires disclosure of the nutritional content of standard menu items at chain restaurants and food sold from vending machines.

Medicaid Payments for Hospital-Acquired Infections - Prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections.

Graduate Medical Education - Increases the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots and promotes training in outpatient settings.

Medicare Independent Payment Advisory Board - Establishes an Independent Advisory Board, comprised of

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15 members, to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds targeted growth rates.

Medicaid Long-Term Care Services - Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services and establishes the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

2012 Provisions

Accountable Care Organizations in Medicare - Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.

Uniform Coverage Summaries for Consumers - This provision of the Affordable Care Act (ACA) that requires private individual and group health plans to provide a uniform summary of benefits and coverage (SBC) to all applicants and enrollees. The intent is to help consumers compare health insurance coverage options before they enroll and understand their coverage once they enroll.

Medicare Advantage Plan Payments - Reduces rebates paid to Medicare Advantage plans and provides bonus payments to high–quality plans.

Medicare Independence at Home Demonstration - Creates the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home.
Medicare Provider Payment Changes - Adds a productivity adjustment to the market basket update for certain providers, resulting in lower rates than otherwise would have been paid.

Fraud and Abuse Prevention - Establishes procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid, and CHIP; requires additional entities to register under Medicare.

Annual Fees on the Pharmaceutical Industry - Imposes new annual fees on the pharmaceutical manufacturing sector.

Medicaid Payment Demonstration Projects - Creates new demonstration projects in Medicaid for up to eight states to pay bundled payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as accountable care organizations to share in cost-savings.

Data Collection to Reduce Health Care Disparities - Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

Medicare Value-Based Purchasing - Establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and requires plans to be developed to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.

Reduced Medicare Payments for Hospital Readmissions - Reduces Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions.

2013 Provisions

State Notification Regarding Exchanges - States indicate to the Secretary of HHS whether they will operate an American Health Benefit Exchange. Implementation: January 1, 2013.

Closing the Medicare Drug Coverage Gap - Begins phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% in 2020, in addition to the 50% manufacturer brand-name discount). Implementation: January 1, 2013.

Medicare Bundled Payment Pilot Program - Establishes a national Medicare pilot program to develop and evaluate making bundled payments for acute, inpatient hospital services, physician services, outpatient hospital

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services, and post-acute care services for an episode of care. Implementation: January 1, 2013.

Medicaid Coverage of Preventive Services - Provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with no patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations. Implementation: January 1, 2013.

Medicaid Payments for Primary Care - Increases Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding). Implementation: January 1, 2013 through December 31, 2014.

Itemized Deductions for Medical Expenses - Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income; waives the increase for individuals age 65 and older for tax years 2013 through 2016. Implementation: January 1, 2013.

Flexible Spending Account Limits - Limits the amount of contributions to a flexible spending account for medical expenses to $2,500 per year, increased annually by the cost of living adjustment. Implementation: January 1, 2013.

Medicare Tax Increase - Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income for higher-income taxpayers. Implementation: January 1, 2013.

Employer Retiree Coverage Subsidy - Eliminates the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments. Implementation: January 1, 2013.

Tax on Medical Devices - Imposes an excise tax of 2.3% on the sale of any taxable medical device. Implementation: January 1, 2013.

Financial Disclosure - Requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. Implementation: Report to Congress due April 1, 2013.

CO-OP Health Insurance Plans - Creates the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit, member-run health insurance companies. Implementation: CO-OPs established by July 1, 2013.

Extension of CHIP - Extends authorization and funding for the Children's Health Insurance Program (CHIP) through 2015 (current authorization is through 2013). Implementation: Fiscal year 2013.

Medicare Disproportionate Share Hospital Payments - Reduces Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increases payments based on the percent of the population uninsured and the amount of uncompensated care provided. Implementation: October 1, 2013.

Medicaid Disproportionate Share Hospital Payments - Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires the Secretary to develop a methodology for distributing the DSH reductions. Implementation: October 1, 2013.

2014 Provisions

Expanded Medicaid Coverage - Expands Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL and provides enhanced federal matching payments for new eligibles. Implementation: January 1, 2014 (states have the option to expand coverage to childless adults beginning April 1, 2010).

Presumptive Eligibility for Medicaid - Allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations. Implementation: January 1, 2014.

Individual Requirement to Have Insurance - Requires U.S. citizens and legal residents to have qualifying

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health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions). Implementation: January 1, 2014.

Health Insurance Exchanges - Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Exchanges will have a single form for applying for health programs, including coverage through the Exchanges and Medicaid and CHIP programs. Implementation: January 1, 2014.

Health Insurance Premium and Cost Sharing Subsidies - Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals. Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the Exchanges, while cost sharing subsidies are available to those with incomes up to 250% of the poverty level. Implementation: January 1, 2014.

Guaranteed Availability of Insurance - Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges. Implementation: January 1, 2014.

No Annual Limits on Coverage - Prohibits annual limits on the dollar value of coverage. Implementation: January 1, 2014.

Essential Health Benefits - Creates an essential health benefits package that provides a comprehensive set of services, limiting annual cost-sharing to the Health Savings Account limits ($5,950/individual and $11,900/family in 2010). Creates four categories of plans to be offered through the Exchanges, and in the individual and small group markets, varying based on the proportion of plan benefits they cover. Implementation: January 1, 2014.

Multi-State Health Plans - Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Implementation: January 1, 2014.

Temporary Reinsurance Program for Health Plans - Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Implementation: January 1, 2014 through December 31, 2016

Basic Health Plan - Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. Implementation: January 1, 2014.

Employer Requirements - Assesses a fee of $2,000 per full-time employee, excluding the first 30 employees, on employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees. Implementation: January 1, 2014.

Medicare Advantage Plan Loss Ratios - Requires Medicare Advantage plans to have medical loss ratios no lower than 85%. Implementation: January 1, 2014.

Wellness Programs in Insurance - Permits employers to offer employees rewards of up to 30%, potentially increasing to 50%, of the cost of coverage for participating in a wellness program and meeting certain health-related standards; establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market. Implementation: Changes to employer wellness plans effective January 1, 2014; 10-state pilot programs established by July 1, 2014.

Fees on Health Insurance Sector - Imposes new fees on the health insurance sector. Implementation: January 1, 2014.

Medicare Payments for Hospital-Acquired Infections - Reduces Medicare payments to certain hospitals for

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hospital-acquired conditions by 1%. Implementation: Fiscal Year 2015.

2015 Provisions

Increase Federal Match for CHIP - Provides for a 23 percentage point increase in the Children's Health Insurance Program (CHIP) match rate up to a cap of 100%. Implementation: October 1, 2015.

2016 Provisions

Health Care Choice Compacts - Permits states to form health care choice compacts and allows insurers to sell policies in any state participating in the compact. Implementation: January 1, 2016.

2018 Provisions

Tax on High-Cost Insurance - Imposes an excise tax on insurers of employer-sponsored health plans with aggregate expenses that exceed $10,200 for individual coverage and $27,500 for family coverage. Implementation: January 1, 2018.

Click Here to view the full Implementation Timeline

Click Here for a pdf version of this summary

How Does The Affordable Care Act Affect Medicare?

The life of the Medicare Trust Fund has been extended as a result of reducing waste, fraud, and abuse, and slowing cost growth in Medicare.
This provides you with future cost savings on your premiums and co-insurance.

The federal government is taking strong action to reduce payment errors, waste, fraud, and abuse in Medicare. The law makes a 10-year, $350 million investment to prevent, detect, and fight fraud in Medicare, Medicaid, and the Children's Health Insurance Program—including criminal efforts to exploit the new law. Visit Stop Medicare Fraud for more information.

In addition to strengthening Medicare, the health care law provides these benefits to seniors:

$250 prescription drug rebate in 2010

50% discount on brand-name drugs in the donut hole in 2011

Closes the donut hole by 2020 (PDF – 1 MB)

Annual wellness exam at no cost to you

No copayment for certain preventive services

Coordination of care between doctors

Improved quality of care at hospitals

Starting in 2014, the Affordable Care Act offers additional protections for Medicare Advantage Plan members by taking strong steps that limit the amount these plans spend on administrative costs, insurance company profits, and things other than health care.

Upcoming Events

January 2013

January 11, 2013: Pensacola, FL. *Post Election Analysis of Critical Aging Issues for State of Florida* —presented by Larry Polivka, PhD. For more information email coa@uwf.edu or call 850-474-3298.

February 2013

February 4, 2013: Tallahassee, FL. *Health Care Reform: Legal and Ethical Questions About Where We Go From Here Conference*—sponsored by the FSU Center for Innovative Collaboration in Medicine and Law and the Florida Bioethics Network in Tallahassee. For further information, please contact Julie Jordan at Julie.jordan@med.fsu.edu or at (850) 645-9473.

February 28-March 3, 2013: St. Petersburg, FL. Association for Gerontology in Higher Education (AGHE) Conference—*Waves of Change: Charting the Course for Gerontology.* Visit http://www.aghe.org for more information.

Helping Seniors Heat Their Homes

There's good news and bad for seniors depending on the Low Income Home Energy Assistance Program (LIHEAP) to heat their homes this winter. The U.S. Department of Health and Human Services has released $3.068 billion in LI-HEAP funding through March. But if the sequester—or automatic federal budget cuts—takes effect Jan. 2, the program would lose $285 million, leaving 290,000 households without heat.

See more on the sequester | Explore LIHEAP funding | Get a LIHEAP fact sheet

FASP Board Members' New Year's Resolutions for the Aging Network

"I don't know that I have a New Year's resolution for the Aging Network, but maybe for us serving the aging population. It is that we never forget the great knowledge that they have brought forth for us to flourish. That we continue to respect our seniors and not reduce them to a lesser status because they may forget somethings (but then, so do we) or look upon them with pity or sorrow because they are slow to answer or not move as quickly as we would wish (but then neither do we). They have wrinkles, but their wrinkles have character far beyond the collagen of youth. But most of all because they have a story to tell that we must listen to and learn from if we are to grow more wise and caring for future generations - our generation who is to succeed them as the next aging generation." – Ellen Campbell

"There is so much happening right now, nationally and in the State of Florida, that has a direct impact on the aging network. It is reassuring to know that though our FASP partners we will continue to bring the needs of our elders to the forefront." – Karen Deigl

"The Aging Network will always be in transition. That's why it's so important to try and anticipate the future." – Nancy Green-Irwin

FASP is on Facebook - Are You?

Do you or does your organization have a Facebook or Twitter account?
We would love to "like" "Friend" and/or "follow" you too.

FASP - Florida Association of Aging Services Providers Facebook page
http://www.facebook.com/home.php?#!/pages/FASP-Florida-Association-of-Aging-Services-Providers/186392068069967

FASP - Florida Association of Aging Services Providers Twitter
http://twitter.com/FLAgingServProv

DOEA - Florida Department of Elder Affairs Facebook page
http://www.facebook.com/pages/Florida-Department-of-Elder-Affairs/128604923878650?sk=wall

FCOA - Florida Council on Aging Facebook page
http://www.facebook.com/home.php?#!/pages/Florida-Council-on-Aging/74320166787

FCOA - Florida Council on Aging Twitter
http://twitter.com/#!/FCOA1

GA FOOD SERVICE, INC.

http://www.sunmeadow.com

UnitedHealthcare® Community Plan

www.uhc.com

SUNSHINE STATE® Health Plan

http://www.SunshineStateHealth.com

TALLAHASSEE Senior Center & Foundation FOR ACTIVE ADULTS
1400 N. MONROE ST.
TALLAHASSEE, FL 32303
850.891.4000
CITY OF TALLAHASSEE SENIOR SERVICES CENTER

www.talgov.com/seniors/seniorshome.aspx

Florida Association of Senior Centers
everything Under the Sun!

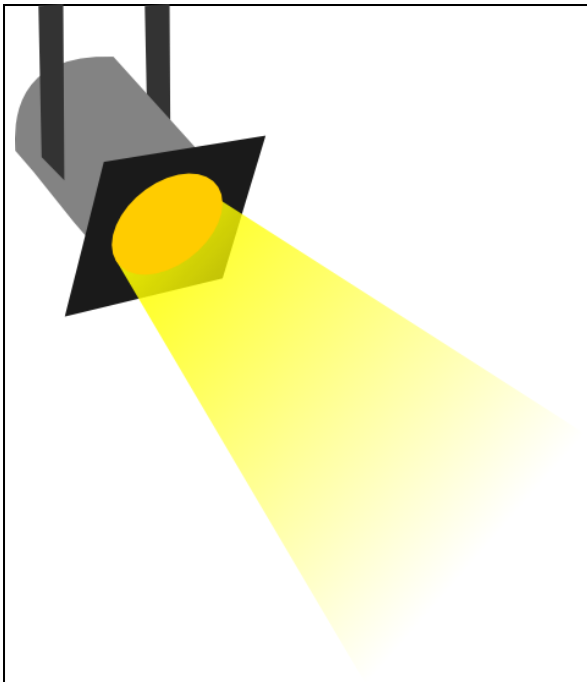
www.floridaseniorcenters.org

ARAMARK

http://www.Aramark.com

MINOTTY EYE FOUNDATION

www.newvisioneyecenter.com



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This issue of the FASP e-Newsletter was brought to you by the generous donation of

Senior Resource Association

Providing activities, education and services

www.seniorresourceassociation.org

The intent of the FASP Newsletter is to keep you informed about program updates and information relating to aging services providers. If you have any comments about the newsletter, suggestions on ways to improve it and/or items you would like included, please contact FASP by e-mail at moreinfo@fasp.net or by phone at (850) 222-3524.

The mission of FASP is to support and advocate for public and non-profit organizations engaged in the provision of community-based services to Florida's elders to improve their quality of life.

Mark your calendars now!

The 2013 Florida Conference on Aging
will be held
August 12-14, 2013
at the
J.W. Marriott Grande Lakes in Orlando