

# our CHANGING HEALTH CARE SYSTEM:

## The Affordable Care Act and Beyond

Health care reform has been debated, passed, debated some more, and reported on extensively. Experts are busy trying to put the reforms into practice and other experts are trying to predict the future in terms of cost savings, outcomes, and access.

For CALA members, the questions are a little more specific: *What does this mean for Assisted Living as a model of care? What impact will the reforms have on Assisted Living as an employer?*

The health care system is undergoing fundamental changes in how care is accessed, delivered, and paid for. These changes are intended to expand coverage, reduce costs, and achieve better outcomes. More personal responsibility—a.k.a., the individual mandate—is intended to bring *almost* everyone into the system, thus spreading the risk and lowering the cost of care. Changes to the reimbursement system are altering incentives and changing practice as, for example, hospitals work to reduce readmissions or face reduced Medicare payments. Health care reform also impacts the type of health coverage that employers offer to their workers and how that coverage is purchased and paid for.

The changes to the health system won't just affect doctors, hospitals, patients, and employers, but will also have far-reaching ripple effects on the long-term services and support systems, including Assisted Living. How will these changes affect Assisted Living providers and what opportunities do they present?



# the ACA timeline

- Dependent children can stay on parent's plan until age 26
- Ban on lifetime coverage limits
- Some preventive services with no out-of-pocket costs
- Rescission restrictions
- No pre-existing condition exclusions for children
- Insurers rebating enrollees if the company spent less than 80% of premiums on health care
- Tax credit up to 35% for for-profits (up to 25% for non-profits) for qualifying small businesses that provide coverage to employees

PRE-2013

2013

- Limits on annual contributions to medical Flexible Spending Accounts
- New taxes and fees on medical device manufacturers, health insurers, brand name drugs
- Additional taxes on individuals earning more than \$200,000 and couples earning more than \$250,000 in 2013

- No pre-existing condition exclusions for adults
- Most individuals required to have insurance or pay a fine/tax
- To help low-income individuals, Medi-Cal will be expanded and government subsidies will be available for some who don't qualify for Medi-Cal
- Other uninsured individuals (and some employers) will find coverage through Covered California, California's health insurance exchange
- Employer fee of approximately \$63 per employee per year (until 2017) on all "major medical" insurance plans, including those provided by employers and those purchased individually by consumers
- Increase in small business tax credit on health insurance to up to 50% (up to 35% for non-profits) for qualifying businesses
- Fines on businesses with 50 or more employees and at least one full-time employee who receives subsidized insurance through the exchange

2014

2018

Excise tax on so called "Cadillac" plans that are deemed too generous

## The ACA Timeline

The Affordable Care Act (ACA) was signed into law in March 2010 with the goals of

- ▶ Reducing number of uninsured (by 32 million)
- ▶ Reducing costs over time (slow rate of increase)
- ▶ Improving outcomes through coordinated care

These goals and objectives have been vetted and widely reported. Implementation details have been slower to evolve as the government develops rules and health care providers organize their approach to care delivery. There's no one initiative to meet these goals, but rather a package of reforms that are being phased in over a period of several years.

## Changing Incentives

A cornerstone of the reforms is a change to the incentives within the system itself. The system is shifting from fee-for-service to a more coordinated, integrated, managed, and outcomes-based approach. Payments will be more closely linked to quality, not quantity. This is affecting hospitals, insurers, and new Accountable Care Organizations (ACOs) created under the ACA. The concept isn't new; managed care is based on this approach, and California has a long track record with managed care in the private sector. But the ACA includes some nuances that are intended to avoid some of the challenges and criticisms HMOs had in their early years.

## Accountable Care Organizations

The ACA establishes ACOs as teams of physicians, hospitals, and other providers who share responsibility for providing appropriate and effective care. In California, there are 22 ACOs, led almost exclusively by physician groups. Under the *Shared Savings ACO*, fee-for-service will continue, but with incentives to meet quality benchmarks. *Pioneer ACOs* assume greater risk and can achieve additional savings. ACOs are very similar to HMOs, except they are not closed systems. In other words, enrollees are not restricted to ACO providers. The closed system approach, while contributing to a cost-effective system, is often criticized by consumers and consumer advocacy organizations. Patients fear having no choice in referrals or being forced to change doctors with whom they have long-standing relationships. Under the ACO approach, consumers will be able to see the specialists of their choice and may not even know their doctor is participating in an ACO.

It is expected that ACOs will focus heavily on prevention and care management. They'll have a stronger stake in whether or not a patient takes medications as directed, has access to nutritious meals, adheres to special diets, and is able to get to follow-up appointments.

## Hospital Readmissions

Even outside of ACOs, the focus is shifting to prevention. Since October 2012, hospitals are facing penalizations for excess readmissions for three conditions: congestive heart failure, acute myocardial infarction, and pneumonia. At least four more conditions are expected to be added in 2015. This means that, instead of more reimbursement for each hospital stay, hospitals are now incentivized to help keep patients out of the hospital when possible. This shift is intended to control Medicare spending and achieve better outcomes for patients.

## What Does All This Mean for Assisted Living?

Assisted Living is not part of the health care system, and licensure in California prohibits Assisted Living communities from providing medical care. That being said, our residents are users of the health care system and, in many cases, frequent users due to age and multiple chronic illnesses. So, while not health care providers, Assisted Living does offer vital supportive services that directly impact our residents' interaction with the health care system.

### What will physicians, hospitals, health plans, and consumers be interested in when it comes to Assisted Living?

- ▶ Reducing unnecessary hospital readmissions
- ▶ Promoting appropriate use of the health system
- ▶ Ensuring safe transitions of care between settings
- ▶ Ensuring our residents follow their treatment plan/ discharge orders
- ▶ Taking steps to promote general wellness

### What drives unnecessary readmissions or interactions with the health system?

- ▶ Failure to take medications as directed
- ▶ Inadequate nutrition and hydration
- ▶ Failure to notice changes in condition
- ▶ Missed doctor appointments
- ▶ Depression/isolation
- ▶ Lack of understanding of the discharge process
- ▶ Calls to 9-1-1 instead of accessing more appropriate medical service

## What can Assisted Living Do?

- ▶ Begin tracking transfers to the emergency room so you have data to share with local hospitals and physician groups. CALA has developed the Acute Care Transfer Log, which will help members keep a record of these numbers. In addition, those who use the Log are encouraged to participate in CALA's quarterly survey which will collect data for members to share with health care providers.
- ▶ Support your residents by being present during the discharge instruction discussion when the resident

is returning from the hospital. In a recent meeting with CALA's Health Care Reform Task Force, a hospital representative said, "The hand-off from one care setting to the other is critical in lowering admissions." Ask the resident and resident's responsible person if a community staff person can be present during a discharge.

- ▶ Consider respite services. Some individuals who may be ready to leave the hospital won't require 24-hour skilled care, but are not quite ready to be home alone, even with a few hours of in-home assistance. Assisted Living can provide 24-hour care and supervision in a residential setting that may be more cost effective than other options.
- ▶ Build relationships with a variety of health care and supportive services providers. CALA has always encouraged this, but it is now more important for hospitals, physician groups and others to understand what Assisted Living can do and how residents can benefit. To begin a new conversation, or continue building an existing relationship, follow these tips:

**tips**

## FOR COMMUNICATING WITH HEALTH CARE PROVIDERS:

1. **TALK** to the right person. When contacting a hospital, ask for the case management department or discharge planning. You may also want to contact local medical or hospital societies, which can be found in most areas.
2. **TELL** the story of Assisted Living. Focus on education about requirements and benefits of Assisted Living as a whole. CALA has developed a brochure, "Choosing Assisted Living," which can help you do just that.
3. **DEMONSTRATE** your worth. Gather data on readmission rates using CALA's Acute Care Transfer Log to show that you can help keep these numbers down. In a CALA Health Care Reform Task Force meeting, a representative of a physician group also suggested gathering data on "wellness programs, medication reconciliation, or patient safety checks. We want to work with partners that have quality programs."