Health care up close: What else the Affordable Care Act does

by Robert D. Francis in the October 3, 2012 issue

Read the sidebar article on providers as employers.

It's hard to believe that the Patient Protection and Affordable Care Act (ACA) was passed only two and a half years ago. I've lived in Washington, D.C., and worked on federal policy for almost six years, and it strains my memory to recall a time when this town wasn't besieged by rallies and protests about the health-care reform law.

Yet despite this endless debate, there is widespread ignorance about what the ACA actually does. People often point out this fact and go on to explain the law's consumer-focused and generally popular provisions, such as the rule allowing young adults up to age 26 to stay on their parents' insurance plan and the rule that prevents people from being excluded from coverage because of a preexisting condition.

I'm focusing here on everything else the ACA does. Health care is vastly complex, as anyone who has dealt with an insurance company or tried to pick a Medigap plan can attest. The reform law is complex as well—and it contains a number of elements that are not widely discussed or understood.

To help shed light on these aspects, I talked to representatives of several faith-based (in this case all Lutheran-affiliated) health and human service organizations to see how the ACA is affecting them. Together, their responses tell some of the untold stories of health-care reform.

New cracks for patients to fall through: For many, the ACA's central achievement is the steps it takes to greatly reduce the ranks of the uninsured. The July 25 editorial in the Century helpfully explains several of the ways the law seeks to accomplish this goal. Beginning in 2014, uninsured people under age 65 with income below 133 percent of the federal poverty level will become eligible for Medicaid, the federal-state program that pays for health care for the poor, long-term care for the elderly and services for people with disabilities. For states that choose to take up this Medicaid expansion, the federal government will pick up the full cost from 2014 to 2016 and 90 percent of it thereafter (more on Medicaid in a moment).

Also starting in 2014, uninsured adults with incomes between 100 and 400 percent of the poverty level will have access to sliding-scale federal subsidies for use in the new Affordable Health Exchanges, state-based online marketplaces of private insurance plans that meet certain criteria. Americans will be required to either carry qualifying insurance or pay a penalty; hardship exemptions will be available for those who still can't afford coverage.

These expansions in coverage are welcome news to safety-net health providers such as Lutheran HealthCare, a faith-based health system in southwest Brooklyn. Lutheran HealthCare, said Donald A. Stiger, senior vice president for mission and spiritual care, has "a mission that compels us to provide vast amounts of charity care to the medically indigent." So the hospital "welcome[s] all that [the ACA] means for justice—the expanded coverage, increased access to care and affordability."

For Lutheran HealthCare the promise of reform is this: fewer uninsured people will be coming through the doors. At present, 15 percent of the hospital's expenses go to treating its many patients who lack adequate insurance or any at all. This means that Lutheran relies on something called disproportionate share hospital payments. These government-subsidized DSH payments partially offset the cost of providing this care.

This is where a lesser-known wrinkle comes into play. In 2014, the ACA will begin to scale back DSH payments, under the assumption that providers will no longer need them because most Americans will have adequate insurance. But in Stiger's view this policy ignores those who will still be underinsured. And then there are the millions of undocumented residents who are excluded from the ACA altogether. Undocumented immigrants (and even some legal ones) are currently ineligible for regular Medicaid, and the new law won't change this. The ACA even prohibits the undocumented from using their own money to buy insurance in the new exchanges.

Lutheran estimates that of its 64,000 emergency visits in 2011, 25 percent were by undocumented patients. Even after all the ACA's coverage expansions are complete, such patients will remain largely uninsured—but they will still come to Lutheran's emergency room when they need care. The hospital expects to lose 75 percent of the $51 million it currently receives in DSH payments. For a provider that already operates at a profit margin of less than 1 percent, this will be devastating.

Lutheran has been working with other safety-net providers to let legislators know that, without a DSH subsidy, disaster is looming. Stiger says that elected officials "always express surprise and then concern. But 2014 is coming quickly, and we still don't have a resolution in sight."

In June, the Supreme Court upheld most of the ACA, but its decision also gave providers such as Lutheran another reason to suspect that the ranks of the uninsured will not decline as dramatically as hoped. Because the court held that Congress cannot threaten to withhold all Medicaid funding from states that decline to expand coverage, the ACA's Medicaid expansion has essentially become optional, left to each state's discretion.

The ACA is designed to add 30 million to the ranks of the insured, and the Medicaid expansion is responsible for more than half of these. But the court's unique ruling has created a new "donut hole" gap in coverage: federal subsidies for buying insurance don't kick in until 100 percent of the poverty line, because the plan was for Medicaid to cover everyone earning less. But now states can choose to maintain a lower income cap for Medicaid coverage—leaving a middle group without coverage.

Since the court's ruling, some Democratic governors have said they will expand Medicaid coverage, and some Republican governors have said they will not. Most,

however, have expressed caution, and many will likely wait until after the November elections to decide. This means that a cornerstone provision of the health-insurance expansion remains uncertain, and it will play out differently from state to state over the coming months and beyond.

In the meantime, millions of the uninsured are in limbo. And with the DSH payment reduction looming, safety-net providers like Lutheran will continue to see a significant number of uninsured patients.

Providers adapt or die: However misunderstood they are, the health-care law's coverage provisions have at least received *some* attention. The same can't be said for the ways that the ACA is changing how health care will be delivered and paid for.

Observers of the American health-care system often argue that the fee-for-service model—which pays providers based on the quantity of procedures, not the quality of care—leads to higher costs and poorer health. In a 2009 *New Yorker* article, physician Atul Gawande compares health care to building a house:

> The task requires experts, expensive equipment and materials, and a huge amount of coordination. Imagine that, instead of paying a contractor to pull a team together and keep them on track, you paid an electrician for every outlet he recommends, a plumber for every faucet, and a carpenter for every cabinet. Would you be surprised if you got a house with a thousand outlets, faucets, and cabinets, at three times the cost you expected, and the whole thing fell apart a couple of years later?

Much of the U.S. health-care system functions like a building site with no contractor.

But change is taking root. Coordinated care has long existed at the Mayo Clinic and elsewhere; more recently, grassroots experiments in coordination are taking place in unexpected places such as Camden and Newark. These exceptions might eventually be the rule—thanks in part to the ACA.

Health-care reform didn't start the trend toward coordinated care, but it picks up the theme—and it uses the federal government's power of the purse in administering Medicare and Medicaid to begin pulling states and providers in this direction. Health-care providers that don't change will be left behind.

Tim Sheehan, executive director of behavioral health services at Lutheran Social Services of Illinois, notes that “providers are reacting [to] and anticipating” the “overall vision for the direction of health-care provision” that the ACA created. LSSI is not a hospital or medical center, but it does provide behavioral health services that are reimbursable through Medicaid and thus is affected by the reform law’s provisions. “The new game,” says Sheehan, “is about lowering costs and being able to demonstrate outcomes. Small providers would simply die if they tried to do this on their own, so it’s imperative to forge alliances.”

To this end, LSSI and others are developing a collaborative called Together 4 Health. Led by Heartland Alliance, another nonprofit health provider in Illinois, T4H is designing a system it hopes will serve both mission and the bottom line: it will provide effective behavioral health services for disadvantaged populations, and it will also contain costs.

Ultimately, T4H hopes to compete for contracts from the Illinois Department of Children and Family Services. In the past, says Sheehan, the state might have had behavioral health contracts with 50 unconnected organizations. In the future, Illinois will contract with just one or two entities and expect them to coordinate care while keeping costs low.

While LSSI is reacting to Illinois, Illinois is reacting to the ACA. Under the new law’s Medicaid provisions, states have the option to develop “health homes.” In this model, instead of reimbursing providers for each service rendered to a Medicaid beneficiary, a state can contract with a provider or group of providers—a health home—that is then responsible for coordinating care for individuals with chronic conditions.

T4H hopes to be one of these health homes, but it’s not certain that it will be. One fear is that Illinois will just call up a large provider like Humana or Blue Cross Blue Shield and sign a contract. Even if the state chooses a group like T4H, Sheehan estimates that there might be 20 such entities from which to choose. For now, all they can do is be prepared and positioned.

Much of this movement toward coordination and integration is undergirded by the use of electronic health records. While not glamorous, EHRs have the potential to revolutionize the delivery of care. If a patient’s health history exists electronically, it can be shared easily among health professionals, aiding in the coordination of care.

No more faxing or mailing paper records from office to office; no more patients with partial records at unconnected facilities all over town (and beyond); no more doctors having to start from scratch when they see a new patient.

Converting to EHRs may seem like an obvious move. But it puts smaller organizations such as Lutheran Community Services Northwest in a bind. Like LSSI, LCSNW—a $26 million nonprofit with offices throughout Washington, Oregon and Idaho—provides behavioral health services. The contracts for these services come through the county and regional health systems, and the source of payment is primarily Medicaid. These contracts make up 30 percent of LCSNW's revenue, and to keep receiving them the organization will need to coordinate with the larger providers in their area. This means converting to electronic records—which is easier said than done.

The biggest issue is cost. Large health systems are spending millions on these upgrades, but small providers can't necessarily afford this kind of upfront investment. The 2009 stimulus package included more than $25 billion for health information technology (IT) investments and incentives, but many small providers didn't qualify. And strangely, while the ACA has dispersed billions of dollars for other purposes, it includes no dollars specifically for IT upgrades for behavioral health providers who will need to participate in the new world of care coordination.

"This puts us in a tricky situation," says LCSNW president and CEO Roberta Nestaas. "We're left to spend tens—if not hundreds—of thousands of our own undesignated dollars on IT upgrades . . . with no guarantee that our behavioral health contracts will be renewed after all of this investment."

The move toward coordinating care and containing costs has created some uncertainty for providers. Still, the conviction underlying these changes is a sound one: that you get what you pay for, and for far too long our health system has paid for the wrong things. Providers need a financial incentive to work together and to concern themselves with what happens after a patient walks out the door. The ACA sends a clear signal that the day is fast approaching when provider payment will be tied to quality of care—including health outcomes—and not quantity of procedures. This is good news both for patients and for the prospect of controlling health-care costs.

The move to home-based care: Lutheran Social Services of Michigan is also anticipating health-care reform's changes and hopes to be the best-networked provider of long-term care in the state. To that end, it has recently acquired several other health organizations in order to increase the breadth and depth of services it can offer. The group is also ramping up its conversion to electronic health records.

The driving force for LSSM is the conviction that the health-care system must to do a better job of meeting the needs of seniors with chronic conditions. "If you're poor and over 65, your only option for long-term care is an emergency room and then a nursing home," says president and CEO Mark Stutrud. "Like the lepers of Jesus' day, we essentially put these folks on the outskirts—out of sight, out of mind."

The U.S. system of long-term care—care for people with chronic illness or a disability—is largely broken. The picture many people have of long-term care is a nursing home, but it also includes other settings—such as homes—as well as a wide variety of services and supports, from companionship to nonmedical caregivers to skilled medical care. But as anyone who has navigated the long-term care waters knows, the available options can quickly become limited.

For one thing, many people are surprised to learn that traditional Medicare—federal health insurance for the elderly—does not pay for long-term care. Medicaid does, but generally only in institutional settings and only for the poor. A few people carry private long-term care insurance; for everyone else, it comes down to personal savings and family support.

What often unfolds is a sadly familiar story: Dad starts to need assistance with daily tasks, and the family quickly learns that Medicare offers no help. Family members help financially and as caregivers, but Dad's care needs increase—as does the toll on the family. Eventually Dad's care exhausts his savings, making him poor enough to qualify for Medicaid. But because Medicaid doesn't cover most long-term services provided outside an institutional setting, the family decides to move him into a nursing home—even if he prefers to stay at home and doesn't yet require around-the-clock skilled nursing care.

Stutrud is grateful that the reform law aims to change this story by moving toward home- and community-based services. While the ACA doesn't remove Medicaid's payment bias toward institutional care, it does give states ways to offer more support and services in homes and communities. One new program gives states

access to new federal money to invest in expanding options for home-based care; another offers funds specifically for personal attendant services as part of Medicaid. Other provisions extend financial protections against spousal impoverishment and allocate money for training direct-care workers and personal and home-care aides.

The more states can rebalance their Medicaid programs in favor of home- and community-based care, the more options there will be for those in Medicaid to stay at home as long as possible. Along with being what most people prefer, home-and community-based services have the benefit of often being far less expensive than institutional care.

Still, as Ted Goins of Lutheran Services Carolinas points out, there will always be a need for more intensive care that requires residential treatment. With locations in North and South Carolina, LSC primarily provides nursing home care—though Goins dislikes the term for the negative connotations it has taken on. The ACA aims to strengthen the public accountability of such facilities. Among other things, the law requires all nursing homes to comply with “quality assurance performance improvement” regulations. While the actual QAPI regulations have yet to be released, nursing facilities are busily preparing.

The point of the QAPI regulations is to improve care. Goins acknowledges an ocean of difference between the best and worst nursing homes, and he sees some value in what the new rules will do. Still, you won’t catch him jumping for joy at more regulation. He hopes that the new QAPI regime replaces existing reporting requirements instead of simply adding to them.

What’s clear to both Stutrud and Goins is that all people deserve options for their care—and that they should always be in the most appropriate setting possible. Those who require skilled nursing need nursing homes that provide quality care, while those with less acute needs should not be forced by financial considerations to leave their homes prematurely. The ACA moves us closer to making this commonsense approach a reality.

The impact of reform: The ACA’s most committed supporters seem to think the law is without flaw or unintended consequence. For its fiercest opponents, the law is nothing less than an assault on liberty and the American way of life. The story as told by these Lutheran health and human service organizations gets closer to the truth: health-care reform is an incomplete painting, with promising outlines and

hopeful hues but also much that’s yet to be filled in. One thing that is clear: the complete story won’t be fully told for years.

The ultimate measure of the law’s success is whether it moves us closer to a health system in which all people are made whole. Our present system’s failure to live up to this standard is what led many to pursue reform in the first place. Reimagining health care cannot happen in an instant, but the ACA promises to reorient the system toward coordination, accountability, reduced costs and ultimately better care. It also creates pathways to affordable, quality health insurance for millions, despite some of the challenges posed by the Supreme Court’s ruling. We need to take the time to see these ideas through—even as we debate how the law can be improved.

The political battle over health-care reform continues; the law’s fate appears to rest on the outcomes of the November election. Most care providers will stay out of that fray, focusing instead on the more constructive work of exploring the challenges and opportunities of reform itself. This includes providing services “in both established and innovative ways,” says Goins—and it’s a mixed bag. “There’s good and bad, risk and opportunity.”