Tension Between RCFE Regulations and the ACA Quality Care Initiatives?

by Rachael Maxwell-Jolly and Joel Goldman

THE AFFORDABLE CARE ACT (ACA) creates certain quality incentives and measures for health care providers. One of the most expansive provisions of the ACA creates new rules to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs).

Theoretically, the ACO structure creates incentives for health care providers to work together to treat an individual patient across care settings—including doctor's offices, hospitals, and long-term care facilities. What does this mean for RCFEs? To answer that question, let's take a closer look at the ACOs.

The Centers for Medicare and Medicaid Services (CMS) is encouraging providers to organize into ACOs through the payment of incentives of the Shared Savings Program. The Shared Savings Program will reward ACOs that slow their growth in health care costs while meeting performance standards pertaining to quality of care. Under the Shared Savings Program, the ACO providers and suppliers will continue to be paid for services rendered to fee-for-service Medicare beneficiaries in the same manner as they would otherwise. In addition, the participating ACO will be eligible to receive a shared savings payment if the ACO meets the quality performance standards and has generated shareable savings under the performance-based payment methodology described in the rule. Also, some ACOs may be eligible for the Advance Payment program and receive an advance monthly payment of the shared savings they are expected to earn. Pioneer ACOs move beyond fee-for-service and receive bundled payments, but still must meet the same quality measures as the Shared Savings Program ACOs.

Nationally, 27 ACOs enrolled in the program with five in the Advance Payment program in April 2012. By October 2012, 89 new ACOs were enrolled with an additional 15 in the Advance Payment program. In January 2013, 106 ACOs joined with 15 in the Advance Payment program. California saw seven ACOs join in 2012 and nine in 2013. In addition, there are six Pioneer ACOs in the state.

Many ACOs began reporting certain quality data points to CMS for the year 2012. Based on these numbers, CMS will develop benchmarks and quality standards and goals moving forward. These quality measures include preventive care treatment, health education, fall screening, certain types of admissions, and readmission. Those ACOs that participate are highly incentivized to improve these measures due to large savings they could achieve.

Although Assisted Living may be attractive to an ACO as a partner in improving quality measures, there may be an inherent tension between the goals of the ACO and the regulatory requirements of an RCFE. For example, ACOs are required to submit the percentage of beneficiaries hospitalized who were readmitted to a hospital within 30 days following discharge from the hospital for the index admission. However, RCFE regulations require that 9-1-1 be called "immediately" if "an injury or other circumstance has resulted in an imminent threat to a resident's health." We have already

seen numerous examples around the state of tension between this RCFE regulatory requirement and the desire of municipalities—and, frankly, between the regulations and appropriate care—to limit 9-1-1 calls because they will likely result in readmissions. An ACO does not want 9-1-1 to be called in situations that it deems unnecessary, yet an RCFE may be required to do so to avoid potential tort liability and regulatory sanctions. CALA is talking with DSS about this important issue.

Despite possible tensions relating to regulations, CALA members may have opportunities to align themselves with an ACO. RCFEs offer a low cost setting in which ACO patients can be provided with round-the-clock care and supervision, and may be able to assist an ACO to achieve better quality of care. For example, ACOs are required to submit data on the percentage of discharged patients aged 65 years and older who receive a reconciliation of the discharge medications with the current medication list in the medical record within 60 days by the physician providing ongoing care. Studies have shown that the number one reason patients are readmitted to the hospital following an inpatient stay is a failure of the patient to adhere to their prescribed medication regime. And a new report published in the *Journal of the American Medical Association* showed that nearly one-fifth of patients returned to the emergency room within 30 days of discharge, a majority of those revisits occurring before two weeks. Obviously, it is cost-prohibitive to retain a patient in the hospital solely to monitor medications. But RCFEs are perfectly equipped to provide mediation management to a person who has been discharged from the hospital, especially in those critical first weeks.

ACOs are also required to report the percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months. RCFEs can offer monitoring of the discharged patient's condition, help prevent falls by offering ambulation assistance to a person who has been discharged from the hospital in a weakened condition, monitor diets and provide other similar services. In addition, RCFEs can offer a structured pre-surgery setting where an ACO can be assured the patient-to-be is following pre-surgery instructions regarding food intake and medications. RCFEs can also provide a lower cost alternative to extended SNF stays for ACO patients who require a setting that offers 24-hour care and supervision, but who do not need 24-hour skilled nursing care.

There is still much to learn as ACOs develop and the changing incentives modify standards of care. New models that incorporate community-based options will likely be created and tested. Assisted Living has an opportunity to play a new and potentially significant role in this changing system of care. ■

Rachael Maxwell-Jolly is an associate at the law firm of Hanson Bridgett LLP in the Health and Senior Care Section. Joel Goldman is a partner at Hanson Bridgett, founding board member of CALA and nationally known expert on Assisted Living.