

## **The Affordable Care Act (ACA) and Social Work Practice, Education, Research, and Roles Bibliography**

- 1. Andrews, C. M., Darnell, J. S., McBride, T. D., & Gehlert, S. (2013). Social work and implementation of the Affordable Care Act. *Health & Social Work, 38*(2), 67–71.**

The ACA is making significant changes to our health care system; health care professionals, including social workers, will play leading roles in its implementation. The authors believe that social workers are pivotal to achieving the primary goals of the ACA through playing three major roles: patient navigators, care coordinators, and behavioral health counselors. The social work profession needs to develop a well-coordinated strategy to communicate and demonstrate social workers' cost-effective role in the implementation of this legislation.

- 2. Barker, A. R., Londeree, J. K., McBride, T. D., Kemper, L. M., & Mueller, K. (2013, June). The uninsured: An analysis by income and geography. *RUPRI Center for Rural Health Policy Analysis Rural Policy Brief, Brief No. 2013-6*.**

Using the Census Bureau's Small Area Health Insurance Estimates data, this policy brief reports on how ACA implementation could affect rural and urban uninsured populations. It focused on several findings related to Medicaid expansion. Medicaid expansion will be important in rural areas because a higher proportion of the rural uninsured when compared to urban uninsured has an income at or below 138% of the Federal Poverty Line. Secondly, the proportion of rural uninsured varies by region. Finally, regional differences in state decisions to implement Medicaid expansion could have a disproportionate effect on rural residents.

- 3. Centers for Medicare and Medicaid Services. (2013, March). *Independence at home demonstration fact sheet*. Retrieved from [http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/IAH\\_FactSheet.pdf](http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/IAH_FactSheet.pdf)**

This fact sheet provides an overview of the Independence at Home Demonstration, which is a service delivery and payment incentive model created by the ACA to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. It is directed by a team of physicians and nurse practitioners (the home-based primary care teams), and awards incentive payments to health care providers who meet required quality measures and Medicare expenditures. This fact sheet also includes information on participating practices requirements, eligible beneficiaries, and the application process.

- 4. Collins, S. (2013, June). Strategies for strengthening health care social work in the health reform era. *Practice Perspectives Newsletter*. The National Association of Social Workers. Retrieved from <http://www.socialworkers.org/assets/secured/documents/practice/health/strengtheninghealthcaresocialwork.pdf>**

A rapidly changing health care system presents new opportunities for social workers and also highlights critical areas of change for the profession. With more health care institutions focusing on reducing use and improving patient outcomes, there is growing need for an enhanced research base that shows the value of social work interventions. The author also presents emerging opportunities for social workers in a variety of health care settings from emergency department services to palliative care. Furthermore, the ACA's demonstration projects involving Accountable Care Organizations and health homes create roles most aptly filled by social workers. The author concludes with a number of research, practice, education, and policy recommendations to strengthen and publicize the distinctive skill set of health care social workers.

**5. Darnell, J. S. (2013). Navigators and assisters: Two case management roles for social workers in the Affordable Care Act. *Health & Social Work, 38(2), 123–126.***

The author describes how social workers' case management skills will help meet the ACA's goals of improving health outcomes and reducing health care costs. Social workers are trained to assess clients' strengths and environments which are congruent with new roles from the ACA such as patient navigators and/or assisters. Social workers can also play a consultative role in the implementation of the ACA to advocate for enrolling hard-to-reach populations.

**6. Golden, R. (2011, August). Coordination, integration, and collaboration: A clear path for social work in health care reform. *Health & Social Work, 36(3), 227–228.***

The author describes the current health care delivery system as fragmented with services provided in multiple settings and funded through several sources. The ACA radically changes this system, shifting from acute, disease-focused interventions to person-centered, coordinated care. Such comprehensive care requires the expertise of social workers who are trained to assess and coordinate care beyond an individual's medical needs. The author highlights several new programs created by the ACA and acknowledges that social workers' roles in these models need to be carefully and sustainably crafted. Furthermore, social work's contributions to the fundamental goals of the ACA, reduced health care use and cost and promote overall well-being, need to be recognized by funding new health care positions for social workers.

**7. Gorin S. (2013, January/February). The future of the Affordable Care Act—A social work perspective. *Social Work Today, 13(1), 22.***

The ACA will expand healthcare coverage through health exchanges and Medicaid expansion. States also have the option of creating their own health programs, which would extend coverage to individuals who do not qualify for Medicaid but have incomes below 200% of poverty. The author highlights a number of key cost-saving measures within the ACA, which help cover the cost of expanding coverage, including: reduced payments to Medicare Advantage plans, reduced reimbursements to hospitals and other providers, and increased revenue from pharmaceutical companies. The ACA is also starting to replace the current fee-for-service system with a more coordinated one. The author cites several threats to the future of the ACA, namely the debate over the budget deficit. The author outlines how social workers can address these challenges by increasing the public's understanding of the ACA, assisting individuals with enrollment, and lobbying in states that have not extended Medicaid or created exchanges.

**8. Grabowski, D. C. (2012). Care coordination for dually eligible Medicare–Medicaid beneficiaries under the Affordable Care Act. *Journal of Aging & Social Policy, 24(2), 221–232.***

The silo fragmented structure of Medicare and Medicaid has been a challenge for beneficiaries who are dually eligible. Poor coordination between the two programs has created conflicting incentives, increased program costs, a lack of care management, and poor quality of care. A pilot program for new delivery and payment models is one example of several provisions outlined in the ACA to address these issues. The author predicts that policymakers will continue to be interested in the dually eligible population, given the aging of the baby boom generation and projected federal and state budget shortfalls.

- 9. Harrington, C., Ng, T., LaPlante, M., & Kaye, H. S. (2012). Medicaid home- and community-based services: Impact of the Affordable Care Act. *Journal of Aging & Social Policy*, 24(2), 169–187.**

The ACA introduces three programs with financial incentives intended to attract states seeking to expand home- and community-based services (HCBS). These are a Community First Choice options to provide attendant care services and supports; amend its state plan to provide an optional HCBS benefit; and rebalance its spending on long-term services and supports to increase the proportion that is community-based. However, these three programs face challenges, such as no minimum standards for access to HCBS and limited financial incentives for states. Thus, the authors believe that as long as states have the option to deny Medicaid HCBS to people who meet the criteria for institutional services, wide variations in access to HCBS can be expected, and access and financial inequities will most likely continue.

- 10. Jacobson, G., Neuman, T., & Damico, A. (2012, April). Medicare’s role for dual eligible beneficiaries. *Medicare Policy, Policy Brief*. The Henry Kaiser Family Foundation. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8138-02.pdf>**

This policy brief describes the roles that Medicare and Medicaid play in providing care for dual eligibles. It also explores how dual eligible beneficiaries differ from others on Medicare in terms of the intensity of their medical needs. Key findings include: dual eligibles in 2008 represented 20% of the Medicare population but 31% of Medicare spending; and they represented 15% of the Medicaid population but 39% of Medicaid spending. Despite these statistics, not all dual eligibles are expensive utilizers of health care—in 2008, 74% were not hospitalized and 16% had Medicare spending below \$2,500.

- 11. Kaiser Commission on Medicaid and the Uninsured. *Policy Brief (April 2013). How is the Affordable Care Act leading to changes in Medicaid long-term services and supports (LTSS) today? State adoption of six LTSS options*. The Henry Kaiser Foundation.**

Under the ACA, states have six financing opportunities to improve access to and delivery of Medicaid long-term services and supports. This policy brief provides an overview of these financing options and the state adoption status of each one. The options include: (a) increased federal funding and expanded eligibility for the Money Follows the Person (MFP) demonstration; (b) new state demonstrations to align financing and integrate care for dually eligible beneficiaries; (c) a new option to provide health home services; (d) a new Balancing Incentive Program; (e) expansion of the home- and community-based services state plan; and (f) a new Community First Choice state plan. The most popular options are the MFP demonstration grants and the financial alignment models for dual eligible beneficiaries. To date, 47 states and Washington, DC have taken steps to adopt at least one option.

- 12. MacKinney, A. C., Vaughn, T., Zhu, X., Mueller, K. J., & Ullrich, F. (2013, July). Accountable care organizations in rural America. *RUPRI Center for Rural Health Policy Analysis Rural Policy Brief, Brief No. 2013-7*.**

This report describes Accountable Care Organizations (ACOs) presence in metropolitan and non-metropolitan (rural) areas. . The Medicare Shared Savings Program and associated demonstrations represent a new health care delivery and payment model in order to support the ACA’s goals of clinical quality, patient satisfaction, and controlled costs. ACO participants (e.g., hospitals and physicians) cannot rely on a business model which prioritizes service volume over clinical quality, patient experience, and lower care costs. Rural hospitals and physicians that focus on improving value over volume are more likely to be successful.

**13. Medicaid’s role for dual eligibles. (2013). The Kaiser Family Foundation. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicoids-role-for-dual-eligible-beneficiaries.pdf>**

“Dual eligible” beneficiaries are low-income seniors and younger persons with disabilities enrolled in both Medicare and Medicaid programs. There are over 9 million dual eligible beneficiaries and they are poorer and sicker than individuals covered by either Medicare or Medicaid. Medicaid covers gaps in Medicare coverage, paying their monthly premiums and the cost-sharing charged for Medicare services.

**14. Miller, E. A. (2012). The Affordable Care Act and long-term care: Comprehensive reform or just tinkering around the edges? *Journal of Aging & Social Policy*, 24(2), 101–117.**

The focus of the ACA is on preventing hospitalizations, with few provisions related to long-term care. These include the Community Living Assistance Services and Supports Act, which was later repealed, incentives and options for expanding home- and community-based care, chronic care coordination, supports for the dual eligibles, and nursing home quality reforms. While these provisions may initially make only marginal modifications, the author argues that these changes may lay the ground work for more comprehensive long-term care reform in the future.

**15. Moon, M. (2012). Medicare and the Affordable Care Act. *Journal of Aging & Social Policy*, 24(2), 233–247.**

This article reviews benefit improvements in Medicare resulting from the ACA, many of which are oriented to achieve savings through slowing the rate of growth in payments to doctors, hospitals, and other providers. These include better protection against the cost of prescription drugs, coverage of preventive services, improved access to primary care physicians and minor improvements for the Medicare low-income population. The author argues that while these changes benefiting older adults are relatively modest and fall short of the “ideal,” they still can improve the effectiveness of Medicare and improve the quality of health care for older Americans.

**16. Reisch, M. (2012). The challenges of health care reform for hospital social work in the United States. *Social Work in Health Care*, 51(1), 873–893.**

The author states that the ACA reflects a revival of the public health focus that characterized health care and social work a century ago. This article describes the history of hospital social work, contemporary challenges in the health care field, and the major provisions of the act that have implications for social work practice in health care settings.

**17. Stone, R. I., & Bryant, N. (2012). The impact of health care reform on the workforce caring for older adults. *Journal of Aging & Social Policy*, 24(2), 188–205.**

The authors summarize how the ACA impacts the elder care workforce, with a focus on direct care workers. Currently, direct care workers lack the training and support necessary for effective care coordination and service integration as required in the ACA's new service delivery models. In addition to inadequate training, it is difficult to recruit and retain direct care workers because of low wages, minimal benefits, and challenging work environments. The authors posit that health care reform will not achieve its intended goals unless there is adequate investment in direct care workers' education, training, and compensation.

**18. Walls, J., Grage, W. F., Ujvari, K., Scully, D., Cho, E. G., & Hall, J. M. (2013, April). Two-thirds of states integrating Medicare and Medicaid services for dual eligibles. *Insight on the Issues*, 8, 1–16.**

Results from a 2012 survey of all 50 states indicate within the next 2 years many states plan to reform their finance services for individuals eligible for both Medicare and Medicaid as well as those receiving home- and community-based services. These integration programs are statewide initiatives, targeting all full-benefit duals, and covering most long-term care services and supports. Many states aim to use risk-based managed care models to deliver integrated services to duals.

**19. Weissert, W. G. (2012). A 10-foot rope for a 50-yard drop: The CLASS Act in the patient protection and Affordable Care Act. *Journal of Aging & Social Policy*, 24(2), 136–151.**

This paper discusses the shortcomings of the Community Living Assistance Services and Supports (CLASS) Act, which underlie its failure to be implemented. The CLASS Act created a new disability payment option for people who did not qualify for existing programs. It also provided a plan for financing home- and community-based care. However, it failed to address skilled nursing home costs and thus would have little impact on older adults who lack private long-term care insurance and are not Medicaid eligible to access nursing home care.

**20. Wiener, J. M. (2012). The CLASS Act: Is it dead or just sleeping? *Journal of Aging & Social Policy*, 24(2), 118–135.**

This paper outlines several design and implementation issues related to the CLASS Act and discusses the primary reasons that it was not implemented. The author argues that the United States needs to find additional ways to finance long-term care to ensure the quantity and quality of services for both adults and people with disabilities of all ages.

**21. Wiener, J. M. (2013). After CLASS: The long-term care commission's search for a solution. *Health Affairs*, 32(5), 831–834.**

The Affordable Care Act's long-term care provisions were modest Medicaid changes and some incentives to states to expand home- and community-based services. The CLASS Act, a voluntary, public, long-term care insurance program for individuals without coverage, was expected to make a big change. In October 2011 the Obama administration decided not to implement the CLASS Act because of uncertainty over whether it would remain fiscally solvent over a required 75-year period. Even though aging baby boomers are increasingly faced with caring for oldest-old parents, they often define this as an individual responsibility and not a sign of systemic problems. Therefore, the author argues that until the personal becomes political, there will be limited support for publicly funded long term services and supports.