HEALTH CARE REFORM

ITS IMPACT ON PHYSICAL THERAPY

UNIVERSITY OF TENNESSEE – CHATTANOOGA
CHATTANOOGA STATE COMMUNITY COLLEGE

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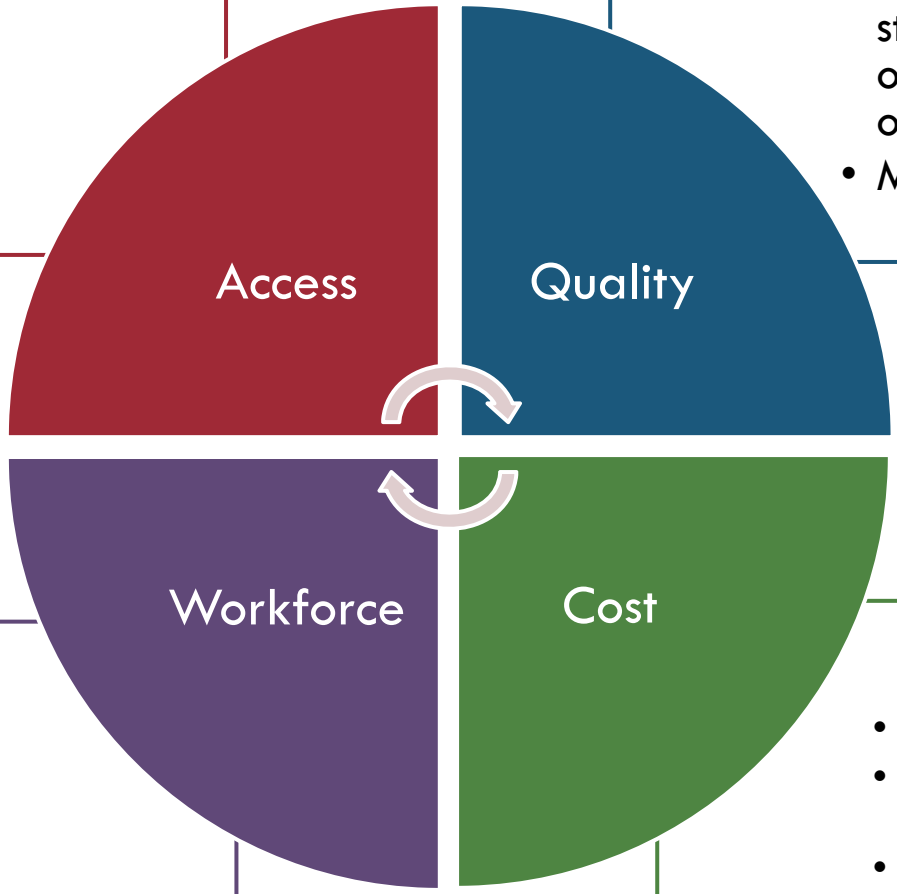
How we got to Health Care Reform

- 45 million uninsured
- Disparities
- Under-insured

- Recommend standard of care only received 50% of the time
- Medical Errors



- Primary Care Shortages
- PT Shortages

- 17% of the GDP
- Therapy Services – Top 5 Growth Areas
- Medicaid Impact on State Budgets

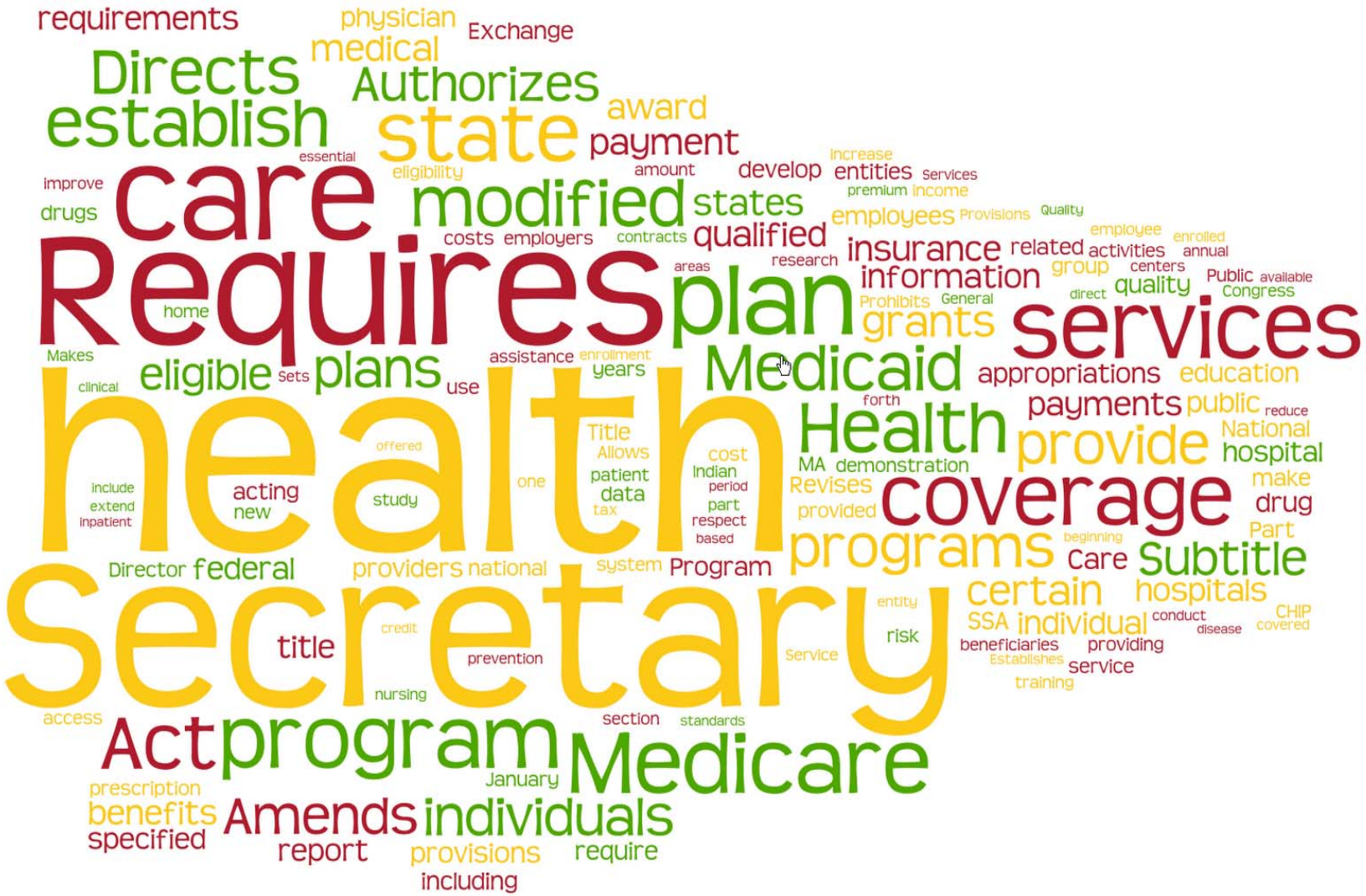
History of Health Care Reform

- 1912: President Theodore Roosevelt proposes Universal Health Care
- 1950: Harry Truman's proposal for national health insurance dies in Congress.
- 1965: Lyndon Johnson wins passage of Medicare and Medicaid.
- 1974: Richard Nixon's proposal to require employers to cover workers dies in Congress.
- 1979: Jimmy Carter's proposal for an employer requirement dies in Congress.
- 1994: Bill Clinton's plan, which includes an employer requirement, dies in Congress (Health Security Act).
- 1997: Clinton and a Republican Congress agree to expand coverage for low-income children (sCHIP).
- 2003: George W. Bush wins passage of Medicare prescription benefit (MMA).
- 2009: Barack Obama proposes to cover the uninsured and contain costs.
- **2010: Barack Obama signs the Patient Protection and Affordable Care – providing 95% coverage in the United States**

Source: Kaiser Family Foundation

PL111-148 & PL 111-152

- HR 3590, the Patient Protection and Affordable Care Act
  - Signed on March 23, 2010
  - PL 111-148
- HR 4872, the Reconciliation Act of 2010
  - Signed on March 29, 2010
  - PL 111-152
- Coverage: 32 million Americans Presently Uninsured for 95% coverage
- Cost: 940 billions dollars over 10 years
- Now Shifts to Implementation from March 2010 through 2020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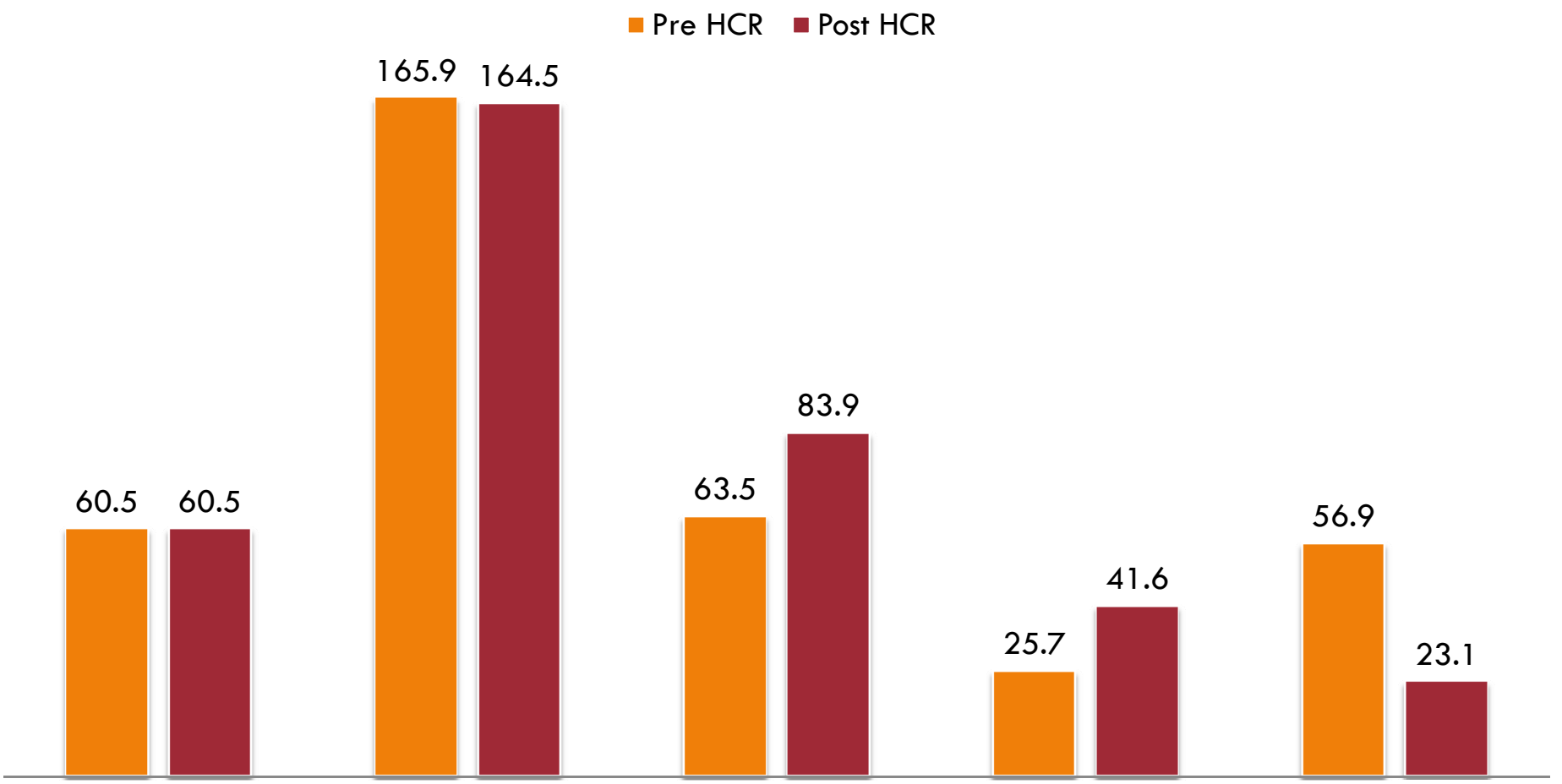
Estimated Effect of HCR in 2019



Source: Office of the Actuary – Centers for Medicare and Medicaid Services – April 22, 2009

HEALTH CARE REFORM:

A LOOK AT THE PATIENT PROTECTIONS AND AFFORDABLE CARE ACT (PL 111-148 AND PL 111-152

Overarching Goals of Health Care Reform

Access to Insurance

- Immediate Insurance Reforms on rating and high risk pools
- Expanded Coverage Through Exchanges (State Based)
- Income Based Subsidies to purchase through Exchanges
- Consumer Protections on Pre-existing Conditions, Young Adults, Arbitrary Limits

Improved Coverage / Benefits

- Minimum Benefit Requirements for Health Plans
- Prohibition of Lifetime and Annual Limits on Coverage
- Expansion of Prevention and Wellness
- Prescription Drug Improvements (elimination of donut hole)

Improved Quality and Cost Reduction

- Expansion of Quality Initiatives
- Establishment of Patient Center Comparative Effectiveness Institute
- Innovation Center at Medicare
- Payment Cuts to Medicare Advantage
- Payment Cuts to Facilities
- Creates Independent Payment Advisory Board

Emerging Themes for Health Care: Does Physical Therapy Fit and How?

Integrated Models of Care – Innovation in Programs	• Accountable Care Organizations • Medical Homes • Role in Medicaid
Re-alignment of Care Models	• Prevention, Wellness & Community Incentives • Chronic Care Management
Refining / Changing Payment Methodologies	• Bundled, Case Rates, Episodic, Per Diem • Expansion of Quality Initiatives
Standardization of Practice	• Documentation / EHR / Health IT • Patient Assessment Instrument to Registries / Profiles • Maintenance of Certification
Enhanced Accountability (Program Integrity)	• Provider Enrollment • Funding Increases for Enforcement • Expansion of Programs for Detention & Recovery

What's the Impact on Physical Therapy

Green Light

- Direct access under the new CMS Center for Innovation
- Extension of therapy cap exceptions process for 2010
- Consumer Protections in Bill (non-discrimination)
- Rehabilitation is part of the essential benefits package

Yellow Light

- Role of PT in new models of care delivery
- Impact of new payment methodologies on PT across the continuum
- Prevention and wellness Initiatives
- Limited progress on self-referral (disclosure / specialty hospitals)

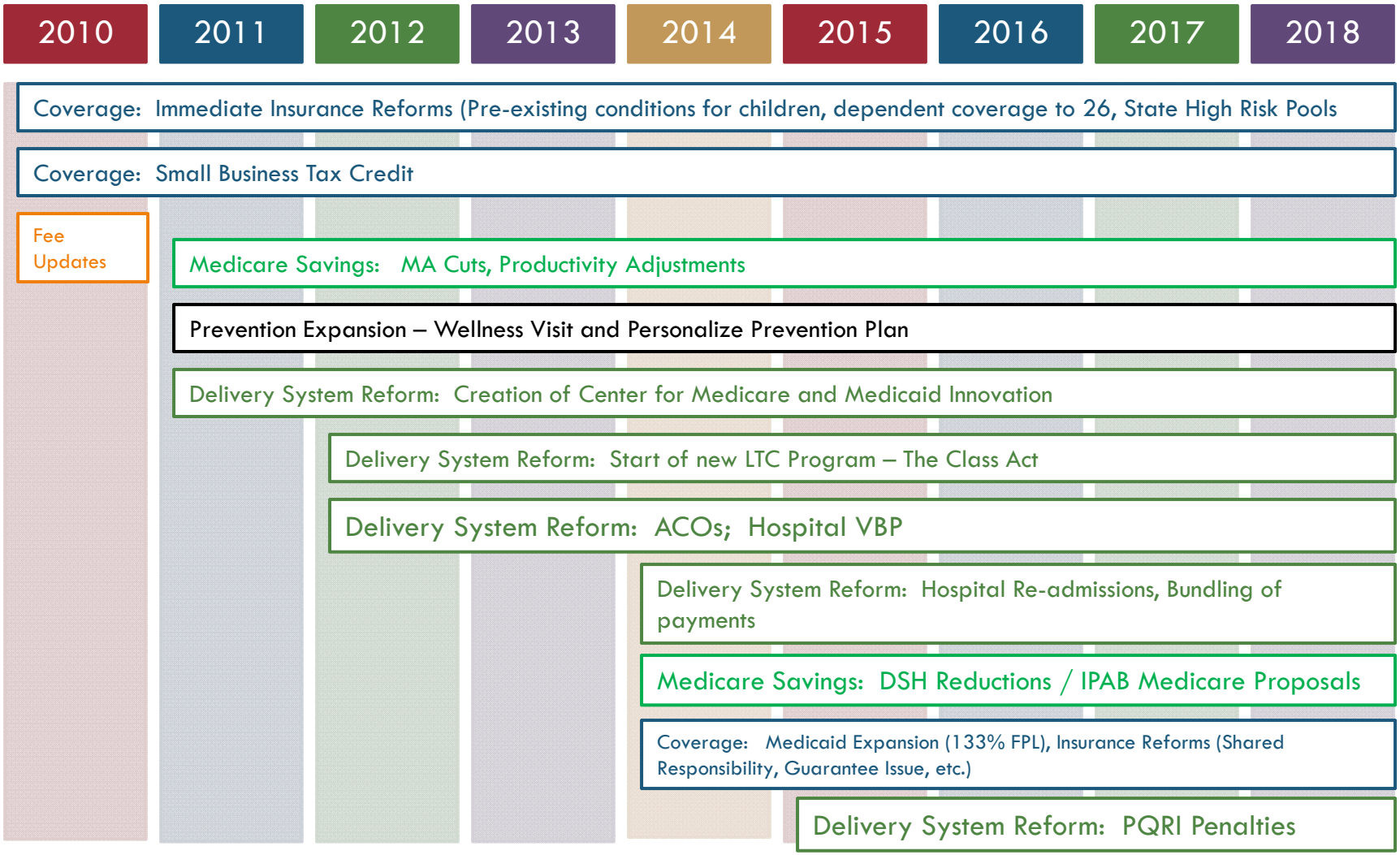
Red Light

- Independent Payment Advisory Commission (will impact cost saving proposals with great autonomy)
- No payment reprieve for outpatient / no update of fee schedule cuts
- Market basket cuts to settings (home health, SNFs, etc.)

HEALTH CARE REFORM:

A LOOK BY IMPLEMENTATION TIMELINE

Timeline of Key Health Reform Provisions



2010

Issue	What the Law Did	Effective Date
Pre-existing Conditions	Insurance companies barred from denying coverage to Children. Temporary national high risk pool for individuals with pre-existing Conditions	Effective Now
Business Tax Credits	Small Business (< 25 FTEs) received tax credits (up to 35% of employers contribution if pay 50% of total.	Now, increases to 50% in 2014
Dependent Children	Mandates coverage for dependent children up to age 26	Effective Now
Prevention	Health insurances companies required to cover preventative services (immunizations, cancer screenings)	Effective Now
Tanning Tax	10% tax on all indoor tanning services	Effective Now
Insurance Coverage	Plans prohibited from lifetime limits on how much they pay out to individual policyholders or rescinding coverage except in fraud	Effective Now
Referral for Profit	Bans new or expanding specialty hospitals, provides for disclosure (advancing imaging services)	Effective Now, pending regs
Commissions	Panels named for the Patient Center Outcomes Research Center and National Workforce Commission	Named this week

2011

Issue	What the Law Does	Effective Date
Insurance Reform	Insurance Companies required to pay rebates to enrollees if they spend less than 80 to 85% the premium dollars on health care services	January 1, 2011
Primary Care	Medicare will pay primary care doctors and general surgeons 10% bonus payment	January 1, 2011 (goes to 2015)
Prevention	Medicare will pay for an annual wellness visit and a personalize prevention plan	January 1, 2011
Medicaid	Start of Medicaid Expansion (Childless Adults < 133% FPL)	January 1, 2011
Payment Reform	.5 bonus payment for PQRI / Quality Report	2011-2014. Penalties – 2015
Innovation	Center for Medicare and Medicaid Services Center for Innovation Started. One of the studies / pilots – Direct Access to PT	January 1, 2011
Tort Reform	Five year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations in health care.	January 1, 2011
Health Saving Accounts / FSA	Revised criteria, $2500 limit, and tax doubled to 20% on ineligible medical expenses	January 1, 2011 (Limit set Jan 1, 2013
Taxes	Fees placed on drug makers and manufacturers	January 1, 2011 (increases in 2013, 2017 and 2018)

2012 - 2013

Issue	What the Law Does	Effective Date
Long Term Care	Establishment of a voluntary long-term care program (The CLASS act).	October 1, 2012
Accountable Care Organizations (ACOs)	Establishment of integrated models of care delivery.	Proposed rule making 2010 Operational 2012
Taxes	New Medicare tax on individuals earning more than $200,000 and couples earning more than $250,000	January 1, 2013
Administrative Simplification	Adoption of single set of eligibility verification and claims status, electronic fund transfers, referral certification and authorization, etc.	January 1, 2013
Out of Pocket Costs	Threshold for deducting health care expenses increase from 7.5% of adjusted gross income to 10%	January 1, 2013
Bundled Payments	Medicare will initiate a pilot program on bundled payments to providers and facilities	January 1, 2013
Co-ops	Creation of Consumer Operated and Orientated Health Plans	January 1, 2013

2014

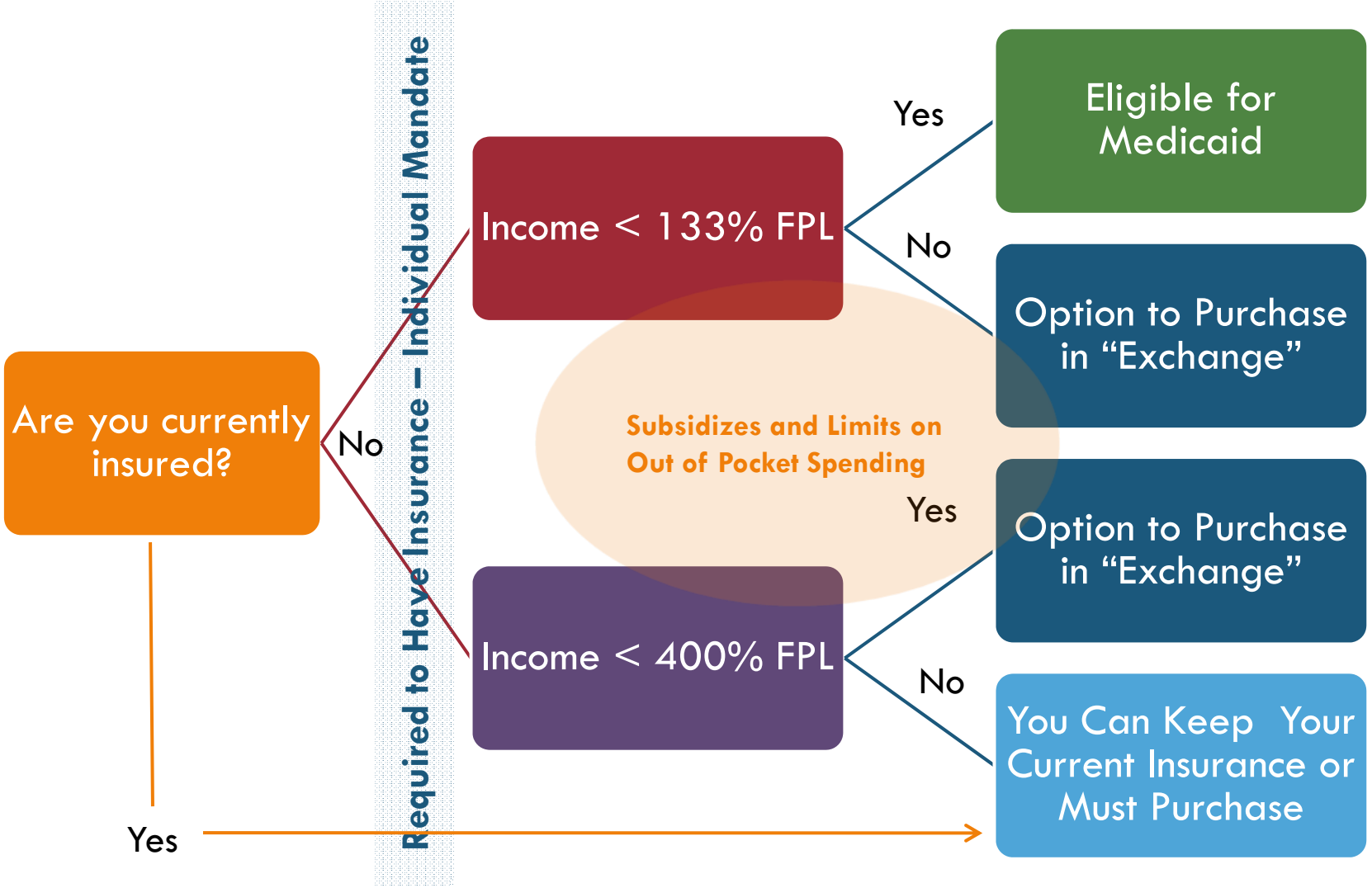
Issue	What the Law Does	Effective Date
Exchange	American Health Benefits Exchange Created. Small Business Health Option Plans Established. Each Exchange will have at least 2 multistate plans operated by Office of Personnel and Management.	January 1, 2014
Essential Benefits Plan	Essential Benefits Program Established, including rehabilitation and habilitation as essential benefits	January 1, 2014
Individual Mandate	Required to have health insurance. $95 fine for individual / $ 285 for family or 1% of taxable income, whichever is greater. Subsidies for 133% to 400% FPL (ranges from 3 to 9.5% of adjusted gross income)	January 1, 2014
Employer Mandate	Employers over 50 FTEs. Must provide meaningful health coverage for face fine ($3000 per employee over first 30 employees)	January 1, 2014
Medicaid Expansion	Coverage expanded to all Americans under 133% Federal Poverty Level ($29, 347 for family of four)	January 1, 2014
Payment Reform	Establishment of Independent Payment Advisory Board	January 1, 2014
Consumer Protections	Non-discrimination, Guarantee Issue, Renewal and Choice	January 1, 2014
Taxes	New fees on health insurance companies	January 1, 2014 (increases in 2015)

2015-2018

Issue	What the Law Does	Effective Date
Individual Mandate	Penalties increase to $325 individual, $975 family or 2% taxable income	January 1, 2015
Interstate Commerce in Health Care Insurance	Permits states to form compacts to sell policies in states within the compact	January 1, 2016
Individual Mandate	Penalties increase to $695 individual, $2085 family or 2.5% taxable income	January 1, 2016
Cadillac Tax	Imposes an excise tax of 40% on insurers of employer sponsored plans with an aggregated value that exceeds $10,200 for an individual, 27,500 for families	January 1, 2018

HEALTH CARE
What It Means to Me

Health Care Reform and You



Health Care Reform and You

Patient	• Elimination of pre-existing conditions • Focus on prevention and wellness • Reduced risk with health care costs
Physical Therapist	• Improved Patient Access • Potential of Comparative Effectiveness • Unknown of Delivery Models and Payment Changes
Business Owner	• Employer Mandate if over 50 employees • Workplace Wellness Initiatives • Changing Delivery Systems & Payment • 1099 Filings &New Taxes
Citizen	• Universal Coverage? (95%) • Individual Mandate Beginning in 2014 • Potentially New Taxes

What Happens in 2011?

- Impact of the 2010 Election
  - Changing Party Control
- Efforts to Modify / Repeal
  - HR 2 – the Job Killing Health Care Bill
    - Vote Scheduled for Wednesday, January 19th in House
  - 1099 Requirement – Most Likely Change
  - De-funding Regulatory Implementation
  - Individual Mandate – Legal Challenges
    - Virginia, Florida and Michigan
    - Will go to Supreme Court

ADDITIONAL REFERENCE SLIDES

ISSUES OF FOCUS IN HEALTH CARE REFORM

Issue in Focus: Bundling

- Directs HHS to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models.
- Establish program by January 1, 2013 for a period of five years.
- Will focus on 8 conditions.
- Gives Secretary Discretion to Expand
- Also Medicaid Demonstration in 8 States

Issue in Focus: Accountable Care Organizations (ACOs)

- Authorizes Medicare to directly contract with an ACOs
  - Networks of physicians and other providers that could work together to improve the quality of health care services and reduce costs for a defined patient population.
  - Participation could include group practices, independent practice associations or other networks of individual practitioners, partnerships of hospitals and professionals, hospitals that employ professionals, and other groups defined by the HHS secretary.
  - Each ACO must have a formal legal structure that will allow it to receive shared savings payments and distribute them among providers, and it must show that it can meet quality and reporting standards to be developed by the Secretary.
  - An ACO must agree to at least a three-year contract and serve an assigned Medicare patient population of at least 5,000.
  - Preference could be given to organizations that also develop ACO arrangements with payers other than Medicare.
  - Notice of Proposed Rule Making in Fall 2010. Operational by 2012

Issue in Focus: Quality

- Establishes non-profit Patient Centered Outcome Research Institute
- Established a "corps" for times of national emergencies
- PQRI - .5 % bonus 2011-2014, penalties in 2015
- Development of national quality strategy
- Increases funding to community health centers and National Health Service Corps
  - New program on school based health centers and nurse managed clinics
- Reporting on areas of disparities

Issues in Focus: Prevention and Wellness

- Requires qualified health plans to provide minimum coverage without cost sharing for preventive services
  - Rated as A or B from the USPSTF
- Medicare and Medicaid coverage for prevention services
  - Actual charges or fee schedule rate under Medicare
  - States that offer under Medicare – 1% increase in FMAP
  - Provides an annual wellness visit with assessment and a personalize prevention plan
- Establishes National Prevention, Health Promotion and Public Health Council to develop national strategy
- Small Employer Grants that establish wellness programs
- Employers eligible for rewards up to 30% increasing to 50% for wellness programming

Issue in Focus: CLASS ACT

- A national, voluntary insurance program for purchasing community living services

- Expands options for people who become functionally disabled and require long-term services and supports
  - WHO: Working adults will be able to make voluntary premium contributions either through payroll deductions through their employer or directly.
  - ELIGIBLITY: Adults with multiple functional limitations, or cognitive impairments, will be eligible for benefits if they have paid monthly premiums for at least five years and have been employed during three of those five years.
  - BENEFITS (defined by Secretary by Oct. 2012): Adults who meet eligibility criteria will receive a cash benefit that can be used to purchase non-medical services and supports necessary to maintain community residence; payments for institutional care are permitted. The amount of the cash benefit is based on the degree of impairment or disability, averaging no less than $50 per day.
  - INTERACTION WITH FEDERAL PROGRAMS (Medicaid): CLASS will be primary payer for individuals who are also eligible for Medicaid.

Issue in Focus: Center for Medicare and Medicaid Innovation (CMMI)

- Sec. 3021 – Establishment of the Center for Medicare and Medicaid Innovation with CMS
- The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures
  - *Medical Homes, ACOs, Innovation Zones, Continuing Care Hospitals*
- 18 designated projects
  - *''(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.*

Issue in Focus: Maintenance of Certification

- **Sec. 10327 – Improvements to the Physician Quality Reporting Program**
  - Defines MOC Program and will require it as part of quality initiatives
  - The MOC program must include requirements:
    - (1) maintain a valid, unrestricted license in the United States,
    - (2) participate in educational and self-assessment programs that require an assessment of what was learned, and
    - (3) demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.
  - A qualified MOC program practice assessment should include:
    - (1) an initial assessment of a practice that is designed to demonstrate use of evidence-based medicine,
    - (2) a survey of patient experience with care, and
    - (3) requirements to implement a quality improvement intervention to address any identified practice weakness, and
    - (4) measurement to assess performance improvement after intervention.

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