HEALTH CARE REFORM
ITS IMPACT ON PHYSICAL THERAPY

UNIVERSITY OF TENNESSEE – CHATTANOOGA
CHATTANOOGA STATE COMMUNITY COLLEGE

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AMERICAN PHYSICAL THERAPY ASSOCIATION (APTA)
How we got to Health Care Reform

- 45 million uninsured
- Disparities
- Under-insured
- Primary Care Shortages
- PT Shortages

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

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

Access

Quality

Workforce

Cost
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 Act — providing 95% coverage in the United States.

Source: Kaiser Family Foundation
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
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?

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
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<tr>
<td>2010</td>
<td>Coverage: Immediate Insurance Reforms (Pre-existing conditions for children, dependent coverage to 26, State High Risk Pools)</td>
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<td>2011</td>
<td>Coverage: Small Business Tax Credit</td>
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<td></td>
<td>Fee Updates</td>
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<td></td>
<td>Medicare Savings: MA Cuts, Productivity Adjustments</td>
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<td></td>
<td>Prevention Expansion – Wellness Visit and Personalize Prevention Plan</td>
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<td></td>
<td>Delivery System Reform: Creation of Center for Medicare and Medicaid Innovation</td>
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<td></td>
<td>Delivery System Reform: Start of new LTC Program – The Class Act</td>
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<td></td>
<td>Delivery System Reform: ACOs; Hospital VBP</td>
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<tr>
<td></td>
<td>Delivery System Reform: Hospital Re-admissions, Bundling of payments</td>
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<td></td>
<td>Medicare Savings: DSH Reductions / IPAB Medicare Proposals</td>
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<tr>
<td></td>
<td>Coverage: Medicaid Expansion (133% FPL), Insurance Reforms (Shared Responsibility, Guarantee Issue, etc.)</td>
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<td>2016</td>
<td>Delivery System Reform: PQRI Penalties</td>
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<tr>
<td>Issue</td>
<td>What the Law Did</td>
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<tr>
<td>Pre-existing Conditions</td>
<td>Insurance companies barred from denying coverage to Children. Temporary national high risk pool for individuals with pre-existing Conditions</td>
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<td>Business Tax Credits</td>
<td>Small Business (&lt; 25 FTEs) received tax credits (up to 35% of employers contribution if pay 50% of total.</td>
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<td>Dependent Children</td>
<td>Mandates coverage for dependent children up to age 26</td>
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<td>Prevention</td>
<td>Health insurances companies required to cover preventative services (immunizations, cancer screenings)</td>
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<td>Tanning Tax</td>
<td>10% tax on all indoor tanning services</td>
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<tr>
<td>Insurance Coverage</td>
<td>Plans prohibited from lifetime limits on how much they pay out to individual policyholders or rescinding coverage except in fraud</td>
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<td>Referral for Profit</td>
<td>Bans new or expanding specialty hospitals, provides for disclosure (advancing imaging services)</td>
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<td>Commissions</td>
<td>Panels named for the Patient Center Outcomes Research Center and National Workforce Commission</td>
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<tr>
<td>Insurance Reform</td>
<td>Insurance Companies required to pay rebates to enrollees if they spend less than 80 to 85% the premium dollars on health care services</td>
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<td>Primary Care</td>
<td>Medicare will pay primary care doctors and general surgeons 10% bonus payment</td>
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<tr>
<td>Prevention</td>
<td>Medicare will pay for an annual wellness visit and a personalize prevention plan</td>
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<tr>
<td>Medicaid</td>
<td>Start of Medicaid Expansion (Childless Adults &lt; 133% FPL)</td>
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<td>Innovation</td>
<td>Center for Medicare and Medicaid Services Center for Innovation Started.</td>
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<td><a href="#">One of the studies / pilots – Direct Access to PT</a></td>
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<td>Tort Reform</td>
<td>Five year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations in health care.</td>
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<td>Health Saving Accounts / FSA</td>
<td>Revised criteria, $2500 limit, and tax doubled to 20% on ineligible medical expenses</td>
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<td>(Limit set Jan 1, 2013)</td>
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<td>Taxes</td>
<td>Fees placed on drug makers and manufacturers</td>
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<td>(increases in 2013, 2017 and 2018)</td>
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<td>Long Term Care</td>
<td>Establishment of a voluntary long-term care program (The <strong>CLASS</strong> act).</td>
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<td><strong>Accountable Care Organizations (ACOs)</strong></td>
<td>Establishment of integrated models of care delivery.</td>
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<td>Taxes</td>
<td>New Medicare tax on individuals earning more than $200,000 and couples earning more than $250,000</td>
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<td>Administrative Simplification</td>
<td>Adoption of single set of eligibility verification and claims status, electronic fund transfers, referral certification and authorization, etc.</td>
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<td>Out of Pocket Costs</td>
<td>Threshold for deducting health care expenses increase from 7.5% of adjusted gross income to 10%</td>
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<td><strong>Bundled Payments</strong></td>
<td>Medicare will initiate a pilot program on bundled payments to providers and facilities</td>
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<td>Co-ops</td>
<td>Creation of Consumer Operated and Orientated Health Plans</td>
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<td>Essential Benefits Plan</td>
<td>Essential Benefits Program Established, including rehabilitation and habilitation as essential benefits</td>
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<td>Individual Mandate</td>
<td>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)</td>
</tr>
<tr>
<td>Employer Mandate</td>
<td>Employers over 50 FTEs. Must provide meaningful health coverage for face fine ($3000 per employee over first 30 employees)</td>
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<tr>
<td>Medicaid Expansion</td>
<td>Coverage expanded to all Americans under 133% Federal Poverty Level ($29,347 for family of four)</td>
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<tr>
<td>Payment Reform</td>
<td>Establishment of Independent Payment Advisory Board</td>
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<tr>
<td>Taxes</td>
<td>New fees on health insurance companies</td>
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<tr>
<td>Individual Mandate</td>
<td>Penalties increase to $325 individual, $975 family or 2% taxable income</td>
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<td>Interstate Commerce in Health Care Insurance</td>
<td>Permits states to form compacts to sell policies in states within the compact</td>
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<tr>
<td>Individual Mandate</td>
<td>Penalties increase to $695 individual, $2085 family or 2.5% taxable income</td>
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<tr>
<td>Cadillac Tax</td>
<td>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</td>
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HEALTH CARE

What It Means to Me
Health Care Reform and You

Are you currently insured?

- Yes
- No

Income < 133% FPL

- Eligible for Medicaid
- Option to Purchase in “Exchange”

Income < 400% FPL

- Subsidizes and Limits on Out of Pocket Spending
- Option to Purchase in “Exchange”

You Can Keep Your Current Insurance or Must Purchase
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.
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.
  - **ELIGIBILITY:** 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.”
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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