Patient Protection and Affordable Care Act: An Overview & Potential Effects on PM & R

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Objective

- To determine the impact of the Patient Protection & Affordable Care Act (ACA) on PM & R
  - Outline major components likely to affect care delivery
  - Current state of implementation of the law
  - Describe demonstration projects
  - Present potential consequences
  - Assess the reality of ACA given fiscal and political environment
Overview of the ACA

- Signed into law March 23, 2010
  - Aims: expand coverage, improve quality, and reduce costs
  - Phased over several years, with most major changes taking effect by end of 2014
    - Mandates individual and employer coverage
    - New regulations on insurance providers
    - Changes Medicare
    - Expands Medicaid
    - Demonstration projects
Constitutionality of the ACA

26 States challenged ACA

January 31, 2011
• Florida v. US Department of HHS struck down the entire law

August 12, 2011
• Court of Appeals for the 11th Circuit upheld an “unconstitutional” ruling of the individual mandate

March 2012
• Supreme Court hearing National Federation of Independent Business v. Sebelius
In a 5-4 decision announced June 28, 2012, the Supreme Court ruled:

1. The Individual Mandate
   The Court upheld the individual mandate under the taxing authority given to Congress by the Constitution

2. Medicaid Expansion
   The requirement of states to participate in Medicaid expansion programs or have their Medicaid funds withheld was declared unconstitutional, the states may voluntarily participate in this funding.

Election of 2012

- Obama
- Strengthened Democratic Majority
- Health care reform likely to move forward for another 4 years
- Many popular changes may become entrenched before opponents regroup
Coverage expansion
Insurance Coverage in the United States (308 million)

16% uninsured 49 million

- Employer (49%)
- Medicare (13%)
- Medicaid (18%)
- Individual (5%)
- Uninsured

Data from Kaiser Family Foundation & Robert Wood Johnson Foundation
Uninsured Rates Among Nonelderly by State, 2010-2011

- <14% Uninsured (13 states & DC)
- 14 to 18% Uninsured (20 states)
- >18% Uninsured (17 states)

National Average = 18.2%

Source: KCMU/Urban Institute analysis of 2011 and 2012 ASEC Supplement to the CPS (two-year pooled data).
Coverage Expansion

- Estimate 30+ million previously uninsured Americans will gain coverage
  - Creates Mandates
    - Individual
    - Employer
  - Expands Medicaid eligibility
  - Creates Health Exchanges
    - outlaws lifetime caps
    - preexisting conditions
    - children to remain on their parent’s plan through age 26
  - Subsidizes coverage on a sliding scale up to 400% ($92K) poverty level (exchanges or employer)

Mandates

Individual

- Insurance or pay IRS ($95-$700) depending on income and calendar year
- Exempt for very poor (if contribution > 8% of income)

Employer

- If employ > 50 workers, must provide insurance or face penalties
  - $2k/employee (after first 30) $40k for 50 staff
  - $3K/employee (after first 30) if they are subsidized
  - Will probably get insurance through the exchanges
Many issues to be worked out

- When does the IRS recoup the penalty?
- Is the penalty enough?
- Will there be a waiting period to buy insurance?
- Will there be layoff in medium sized firms?
Coverage Expansion

EXPANSION OF MEDICAID
Expansion of Medicaid

- State expansion mandate was struck down by Supreme Court
  - States now have option to participate
- ACA expanded eligibility to 138% of Federal Poverty Level
  - ($15k:1/$30k:4)
- By 2019:
  - Enrollment to increase by 10 million
  - Spending to increase by 13.2%

StateHealthFacts.org, a project of the Kaiser Family Foundation. http://statehealthfacts.kff.org/comparereport.jsp?rep=68&cat=17
Medicaid projected enrollment changes by 2019

StateHealthFacts.org, a project of the Kaiser Family Foundation.
Expansion of Medicaid

- Utah - enrollment up by 56%,
  - state spending up 3.7% and federal spending for Utah up 35.3%
- OR - the largest increase in enrollment - 60%
- MA - lowest increase in enrollment - 2%
- States rejecting Medicaid are those with the largest increases in coverage
  - Largest strain on state budgets
  - Federal Funds for two year then a decrease

StateHealthFacts.org, a project of the Kaiser Family Foundation. http://statehealthfacts.kff.org/comparereport.jsp?rep=68&cat=17
Who’s in and who’s out?

- States that have ELECTED Medicaid expansion:
  - AR, CA, CO, CT, DE, DC*, HI, IL, MD, MA, MN, MO, MT, RI, VT, WA, NV, NM, AZ
    - Democratic Governors (except recently announced NV, NM, AZ)

- 22 States are still undecided
  - AK, IN, KS, FL, IO, KY, MI, NE, NH, NJ, NY, OH, OR, ND, NC, PA, TN, UT, VA, WV, WI, WY

- States that have DECLINED Medicaid expansion:
  - AL, GA, ID, LA, ME, MS, OK, SC, SD, TX
    - all participants in lawsuits challenging the Constitutionality of the ACA, and all having Republican Governors
Unanticipated consequences

- Since election, states re-examining participation
  - AZ, NM, NV
  - New Feb 15th “deadline”
- Very complex equation- hidden benefits and costs?
  - Federal support is time limited, long term impact on state budgets to be determined
- Adverse selection by state
- After costs shift to states- benefit/reimbursement cuts?
Expanding Coverage

HEALTH INSURANCE EXCHANGES
Insurance Coverage in the United States
(308 million)

16% uninsured 49 million

Insurance Coverage

- Employer (49%)
- Medicare (13%)
- Medicaid (18%)
- Individual (5%)
- Uninsured

Data from Kaiser Family Foundation & Robert Wood Johnson Foundation
49 million uninsured after ACA

- Individual Mandate (16%)
- Medicaid Expansion eligible (36%)
- Tax Subsidy 138-399% FPL (7.5%)
- Illegal Immigrants (25%)
- Exempt (16%)

Remain uninsured
Health Insurance Exchange (HIX)

- Individual Mandate and not eligible for Medicaid (over 138% FPL)
- Will receive tax subsidies (under 138-400% FPL)
  - $94K for a family of 4
- Employers may buy in as well
- Establishes insurance “exchanges”
- Insurance companies agreed to reform only if universal mandates were put in place (expanding the market)
Health Insurance Exchange (HIX)

- Exchanges increase competition, driving down costs
  - Streamlines delivery of subsidies
  - Disperses costs across larger pool
  - States or default to federal
  - HIXs are NOT insurers- they do not assume risk- they regulate - monitor compliance
Regulations of HIX insurers

- Guaranteed coverage
- No lifetime or annual limits
- Pre-existing limitations eliminated
- Must have minimal essential coverage (Essential Health Benefits/EHB) that cover 10 categories of care
  - Rehab is one category
  - Coverage levels will vary from state to state
  - Minimal rehab coverage determined by state benchmark plan
  - 29 States include specific numbers of rehab services in their definition of EHB
  - 21 States have not define it yet
Decisions on Exchanges

Health insurance exchange status

- Federal exchange (15)
- State run (16+ DC)
- Partnership (5)
- Uncommitted (14)


Benchmark Plans

On November 20, 2012 the Department of Health and Human Services (HHS) released proposed rules on essential health benefits.

Every state must select a benchmark plan from one of the following 4 options:

- One of the three largest small group plans in the state by enrollment
- One of the three largest state employee health plans by enrollment
- One of the three largest federal employee health plans by enrollment
- The largest non-Medicaid HMO plan in the state’s commercial market by enrollment

Federal default if state does not choose a benchmark plan option.
Rehab in EHB Examples

- **Utah**-
  - Outpatient rehab (PT, OT, Speech) covered at 20 visits per plan year
  - Chiropractic not covered
  - Podiatrist visits are fully covered

- **California**-
  - Outpatient Rehab- no visit limit/fully covered
  - Only medically necessary foot care (Podiatry) is covered

Examples

- **New York** -
  - Short term rehabilitation therapy - limited to 60 visits/per condition/per lifetime

- **Maryland** -
  - Outpatient Rehabilitation/ Physical Therapy covered for 50 visits per year
  - Vocational Rehabilitation not covered
Examples

- **Florida**-
  - Outpatient Rehabilitative services covered, (35 visits per year)
  - Chiropractic services covered at 26 annually, deducted from 35 limit for Rehab services

- **Texas**-
  - Outpatient rehabilitative services covered for 35 visits per year
  - Chiropractic services is included in this count
Unintended consequences

- Is the penalty big enough?
  - Guaranteed issue
  - No pre-existing conditions
  - Join when you get sick?
  - Does IRS have the means to collect the penalty?
  - Waiting period?
Coverage Conclusions

- ACA may expand coverage to 32 million
- Expanded coverage may have dramatic impact on the practice of PM&R
- Many new Medicaid patients
  - Reimbursement levels?
- The definition of what constitutes rehab in EHB will vary by state
- Will HIX shape existing Medicaid benefits?
Who is not covered?

- Undocumented aliens (~12 million)
- Those who live in states without expanded Medicaid (est ~2 million). More if additional states decline expansion
  - Individual mandate still applies
- Eligible but not enrolled (up to 12 million)
- These group will have an impact because they will still need to be treated
Restructuring the Delivery System

ACCOUNTABLE CARE ORGANIZATIONS (ACOs)
ACOs are new vertically integrated group (HMOs)
- Medicare only
- At least 5k Medicare benes with core of primary care physicians
- A legal structure to receive and allocate payments
- A management structure that includes physicians and administrators

ACO- shift to quality + capitation

- FFS, DRGs, Bundled Post-acute care
  - ACO incentives: limit utilization
  - Payments would be predetermined and based on average total cost of care
  - Advanced Payment ACO program provides start-up costs to physician and rural providers

- 45% of the US in areas served by at least one ACO
  - 25-31M already receive care through ACOs
  - In past 2 years, ACOs have captured 10% of US
ACOs

- Growth is centered in large population centers
- Hospital Systems are primary backers
- Physician groups are now sponsoring
- 221 ACOs established in 45 states
  - DE, WV, ID, RI, SD only states without (6/2012)
ACOs by sponsoring entity

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Number of ACOs</th>
</tr>
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<tbody>
<tr>
<td>Single Provider ACO</td>
<td>148</td>
</tr>
<tr>
<td>Multiple Provider ACO</td>
<td>43</td>
</tr>
<tr>
<td>Insurer ACO</td>
<td>17</td>
</tr>
<tr>
<td>Insurer-Provider ACO</td>
<td>13</td>
</tr>
</tbody>
</table>

- **67%** Single Provider ACO
- **19%** Multiple Provider ACO
- **8%** Insurer ACO
- **6%** Insurer-Provider ACO

- **118** Hospital System
- **70** Physician Group
- **29** Community-Based Organization
- **4** Insurer
ACO incentive payments

- Medicare Shared Savings Program (MSSP)
  - CMS reward ACOs for reducing total cost
  - Began with 27 ACOs covering 18 states and 375k beneficiaries
- 259 ACO’s enrolled in the program
  - 4 million Medicare beneficiaries
- More than 500 organizations have applied for the third round, began Jan 2013
Outlook for ACOs

- Many establishing ACOs
  - Hopes of winning federal contracts
  - Few have worked out details

- Incentives to rural and physician-based ACOs
  (Advanced Payment ACO model) working, participation increasing
  - Roughly 20% of ACOs include rural health centers, community health centers and critical access hospitals—serving rural and low income communities

- Transformative effect only with wide spread utilization
Payment for Performance - ACOs

- Beginning in 2013 - $850 million to hospitals meeting a series of quality measures
- Funding will come from expected decrease in FFS, and is anticipated to grow over time
- Metrics used will be quality of patient care
- 3 year commitment - year one baseline, followed by two years of assessment
ACO quality measures

- 33 metrics (half of originally sought)
- Includes metrics in 5 general domains:
  - patient/caregiver experience;
  - care coordination and patient safety;
  - preventive health; and
  - caring for at-risk populations
  - patient function
ACO conclusions

- Substantial gaps exist in how an ACO will be structured
- HMO lite?
- Will inpatient rehab be included?
- Will there be a shift to SNFs?
- Impact of ongoing bundling?
- Any effect on outpt musc?
- Effect on spine surgery?
DEMONSTRATION PROJECTS
Demonstration Projects

- Post-Acute Care Bundling
- In the works
  - Patient-Centered Medical Homes
  - Continuing Care Hospital (CCH) Demonstration
  - Independence at Home Demonstration
Bundling

- Post-acute care (IRF, SNF, HH, outpatient)
  - ~15% of all Medicare dollars
  - One of the fastest growing expenditures
- Each provider has a separate Medicare prospective payment system
- Ideal target for consolidation
Bundling

- RTI International conducting the Post Acute Care Payment Reform Demonstration Project
  - Developed Continuity Assessment Record and Evaluation (CARE) for use in inpatient post-acute setting
  - Medicare may use some version CARE to standardize and calibrate payments across post acute settings


The ACA requires CMS pilot program to test the of bundling payments

- Will test acute and post acute episodes of care for 10 different conditions in 2013

- Quality measures used to assess care should focus on:
  - Functional status improvement
  - Rates of discharge and readmission
  - Incidence of health care acquired infection
  - Patient satisfaction

- Case mix adjustment to ensure bundled payments are fair and accurate
Long term goals

- Link bundling with ACO’s
  - ACO’s would be responsible for episodes of acute and post-acute care
  - Payment incentives would:
    - Drive costs down
    - Improve outcomes (pay for performance)
Consequences

- ACOs and HMOs may move toward low cost post-acute care
- IRF need to be competitive on price, or provide much better outcomes
Patient Centered Medical Homes

- US spends majority of $ on those with:
  - Chronic health conditions
  - Individuals with disabilities
- Primary care providers
  - Regular checkups
  - Organize teams of other professional to meet patients’ needs
- Money is saved by integrating different components of care and by reducing hospitalizations (through regular preventative checkups)

Continuing Care Hospitals (CCH)

- New delivery model and to bundle payments for its services
- IRHs could become CCHs
  - Managing more services or partnering with LTCH or hospital based SNFs to form a virtual CCH.
- Capitated payments (LOS + 30 days following discharge)
- HHS has not yet moved forward with this demonstration project.

Questions and Answers for the Continuing Care Hospital (CCH) concept. In: Association AMRP. 2009
Independence at Home Demonstration

- Began December 2011, it is an initiative to provide home health care to chronically ill patients

- Participating organizations provide home visits to 200 or more eligible patients with teams led by physicians, nurse practitioners, or physicians assistants with certain qualifications


IAH Locations

Participating Practices
Aimed at Medicare beneficiaries with chronic conditions

- Required to have “received acute or sub-acute rehabilitation services within the past twelve months” and “require the assistance of another person...for two or more activities of daily living”

- Clinicians may need to adapt to providing their services in a home setting and become familiar with different aspects of home care

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)
Independent Payment Advisory Board

- **Medicare payments:**
  - MedPAC recommendations – Congress approval
  - IPAB sets new policy that Congress must override

- **IPAB**
  - 15 individuals responsible for keeping Medicare spending below set limits
  - Only submit cuts if health care costs increase faster than the general economy
  - Suggestions must be implemented, unless Congress can determine equivalent savings
  - Takes 3/5 vote of Senate to override IPAB determinations
May **NOT**

- Ration health care, raise revenues, raise premiums, share costs, limit benefits to recipients, or change eligibility
- Lower payments to hospitals or hospices before 2020 or lower payments to clinical laboratories prior to 2016

May

- Lower payments to docs, Medicare Advantage, Part-D, SNF, HH, Dialysis, DME, ASCs
Praise of IPAB

- “IPAB was created for the same reason [that] BRAC was created — to remove strong interest that protects the status quo.”
  - Eric Seiber, PhD, a health services management and policy professor at Ohio State University.

- “IPAB is set up to provide a backstop against interest-group pressure on the Congress that makes it difficult to adopt cost-containment measures”
  - Judy Feder, PhD, a professor of public policy at Georgetown University

American Medical Association
http://www.ama-assn.org/amednews/2012/10/15/gvsa1015.htm
Criticism of IPAB

- The AMA has compared the board’s purpose to Medicare’s sustainable growth rate formula, another spending control mechanism developed by Congress that threatens to impose deep cuts to doctor pay.

- Many opposed to healthcare reform for political reasons view the IPAB as an entity that will ration care.
IPAB effects on PM&R

- Medicare budget cuts could take money out of home based health care and durable medical equipment
- ASCs
- Injections and Musculoskeletal Medicine
- Decrease in more expensive post-acute care
Physician Fee Schedule (1997) to control Medicare payments to physicians

Linked MD fee schedule to changes in Medicare costs

Complex formula:
- % change in fees for physicians’ services
- % change in the average number of Medicare fee-for-service beneficiaries
- 10-year average annual percentage change in real GDP per capita
- % change in expenditures due to changes in law or regulations

*All numbers are estimated*
SGR Formula: Increase or Decrease Physicians’ fees

- Formula would have resulted in absolute decreases in reimbursement rates for several years
  - low inflation rates & ballooning costs
- Cuts never been enacted, but have accumulated
- Cuts have grown to >25% but are again delayed until 1/1/2014.
Medicare Uncertainty

- Depending Congress, likely an ongoing threat to the practice of medicine.
  - If physicians or therapists choose to withdraw from Medicare because of its rate structure or serious cuts, beneficiaries’ access to care will be threatened.
  - Medicare & Medicaid now account for 23% of federal spending, up from 15% in 1993.

Other Medicare Reforms in PPACA

- Prior to ACA- Medicare Part D donut hole between $2840 and $4550.

- 2011 gradually increase discounts on brand name medicine in this range, with the goal of covering 75% of costs in this range by 2020.
15 possible changes to Medicare:

- Raise the Medicare Eligibility Age
- Raise Medicare Premiums for Higher-Income Beneficiaries
- Change Medicare to a Premium Support Plan
- Require Drug Companies to Give Rebates or Discounts to Medicare
- Increase Medicare Cost-Sharing for Home Health Care, Skilled Nursing Facility Care and Laboratory Services
- Generate New Revenue by Increasing the Payroll Tax Rate
- Increase Supplemental Plan Costs and Reduce Coverage
15 possible changes to Medicare:

- Raise Medicare Premiums for Everyone
- Strengthen the Independent Payment Advisory Board (IPAB)
- Redesign Medicare’s Copays and Deductibles
- Address the Sustainable Growth Rate (Physician Payment) Formula
- Increase Penalties for Health Care Fraud
- Allow Faster Market Access to Generic Versions of Biological Drugs
- Enroll All Beneficiaries Covered by Both Medicaid and Medicare Managed Care
- Prohibit Pay-for-Delay Agreements
CONCLUSIONS