Understanding the Implications of Legislative Reform on Occupational Therapy Fieldwork and Practice

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- AOTA Secretary 2013-2016
- Chairperson, AOTA Ad Hoc Committee on Health Care Reform Implementation

NEOTEC
New England Occupational Therapy Educational Consortium
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Special Thanks

Thank you to the MD Anderson Cancer Center for their support in allowing me to attend today’s conference.
X-tra Special Thanks to our AOTA Staff!

- Christina Metzler, Chief Public Affairs Officer
- Chuck Willmarth - Director, Health Policy and State Affairs, AOTA
- Jennifer Hitchon, Director of Regulatory Affairs
- Heather Parsons, Director of Legislative Advocacy
- Dan Brown, JD - Senior State Policy Analyst, AOTA

Most of today’s presentation was developed by our amazing policy and legislative staff who work tirelessly on our behalf!
Thanks to the AOTA Ad Hoc Committee on Health Care Reform Implementation

– Brent Braveman, PhD, OTR/L, FAOTA, Chairperson
– Jana Cason, Telehealth
– Monica Robinson, Telehealth/Mental Health
– Amy Lamb, Prevention and Wellness
– Carol Siebert, Chronic Illness/Disease Management
– Jeffery Tomlinson, Benefits
– Pamela Roberts, ACO’s/Medical Homes
Introductions

• My background and limitations………
• Getting to know you………
• Getting to know each other………
Education and Fieldwork

Keys to the future of the Profession and achieving our Centennial Vision
Exercise

• Briefly at your tables:
  – Do a round robin naming one skill, capacity or attribute that entry-level practitioners need to thrive in today’s practice environment
  – Quickly choose one to share with the large group
Advocacy & Power

Keys to the future of the Profession and achieving our Centennial Vision
What do we need to successfully advocate and thrive?

- Awareness of the issues
- Understanding of the key stakeholders
- Appreciation of the process
- Clear articulation of what we want, why and why it is a good idea
- Willingness to knock on big doors and assertively ask for what we want
Health Delivery System Transformation

Acute Health Care System 1.0
- High quality acute care
  - Accountable care systems
  - Shared financial risk
  - Case management and preventive care systems
  - Population-based quality and cost performance
  - Population-based health outcomes
  - Care system integration with community health resources

Coordinated Seamless Health Care System 2.0
- High quality acute care
  - Accountable care systems
  - Shared financial risk
  - Case management and preventive care systems
  - Population-based quality and cost performance
  - Population-based health outcomes
  - Care system integration with community health resources

Community Integrated Health Care System 3.0
- High quality acute care
  - Accountable care systems
  - Shared financial risk
  - Case management and preventive care systems
  - Population-based quality and cost performance
  - Population-based health outcomes
  - Care system integration with community health resources
Overview of Policy Issues
Appropriations and the Budget Process

- **Congressional budgets** provide a framework for spending;
  - House and Senate develop their own budgets;
  - Include ideas for Medicare and other “mandatory” spending;
  - Ideally the House and Senate agree on a budget;
  - Does not have the force of law – internal process.

- **Congressional Appropriations** fund government agencies;
  - Each year, by September 30, Congress must pass a bill to fund the federal budget - called an “appropriations” bill;
  - These funding bills give money to the federal agencies and set all discretionary spending levels;
  - Fund mandatory programs, but not “how”;
  - Without this funding, there would be a “government shutdown”.

Changes to mandatory spending such as Social Security and Medicare require a separate law. (usually happens on Dec. 31!)
President’s Budget

- The President’s Budget is an outline for how he thinks money should be spent. (discretionary and mandatory)

- Congress does not have to follow the President’s budget – but it sets the tone for spending, and spending cuts, especially for programs like Medicare.
President’s Budget: Medicare

- Bundled provider payments for 50% of post-acute care by 2018;
- Penalties of up to 3% for SNFs with high rates of care-sensitive, preventable hospital readmissions in 2017;
- Calling for the repeal of the Medicare Physician Payment system and gradually replace with accountable payment models;
- In 2015, end therapy’s ability to bill as an in-office ancillary service, except in cases “where a practice meets certain accountability standards.”
- Strengthen the Independent Payment-Advisory Board (IPAB) to “reduce long-term drivers of Medicare cost.”
President’s Budget Proposal: Research and Education

• Research:
  – **CDC**: pre-sequester funding
  – **NIH**: 1.5% increase over pre-sequester

• Education: Total proposed 4.6% increase over pre-sequester levels
  – **IDEA B (3-21)**: pre-sequester levels
  – **IDEA C (birth-2)**: slight increase from pre-sequester levels
  – **Head Start and Early Head Start**: 27% from post-sequester
  – **Pre-school For All**: new initiative to provide high quality pre-school to most 4 year olds – paid for with tobacco tax
President’s Budget Proposal: Mental Health

• **Early Detection and Diagnosis** - $55 million to help teachers, first responders and others to recognize mental illness;

• **Healthy Transitions** - $25 million to help young people with mental health or substance abuse issues;

• **Workforce Expansion:** $50 million to train more mental health professionals with a focus on serving students and young adults;

• **School Transformation Grants:** $50 million to help schools implement evidence based behavioral practices to improve school climate;

• **Project Prevent Grants:** $25 million to help schools with pervasive violence break the cycle.
<table>
<thead>
<tr>
<th>Senate Budget</th>
<th>House Budget</th>
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<tr>
<td>Retains Independent Payment Advisory Board (IPAB)</td>
<td>Repeals IPAB, but would limit Medicare payments per beneficiary to GDP + 5%</td>
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<tr>
<td>Sets up mechanism to repeal sequestration</td>
<td>No repeal of sequestration</td>
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<td>Retains Affordable Care Act</td>
<td>Repeals Affordable Care Act, except for the Medicare savings portion</td>
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<td>Increase Medicare eligibility age to same as Social Security</td>
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<td>Beginning in 2024 would create a Medicare Exchange so beneficiaries could select from a private plan or traditional Medicare. Premium support would be provided. Only for those under 65 years of age.</td>
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<td>Would reform the Sustainable Growth Rate (SGR) formula</td>
<td>Would revise and replace the SGR – including changes to health care delivery systems</td>
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<td>Would repeal or increase the outpatient therapy cap</td>
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<td>Would promote improvements in “health care delivery systems”</td>
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Not Just Looking Forward, but Fixing What has Already Happened: The Sequester and Occupational Therapy

- 2% reduction in all Medicare reimbursements (does not include patient copay)
- 5% reduction in almost all Federal Spending including:
  - 5% reduction in Special Education funding = $625 million in cuts to these programs
  - 5% reduction in all Federal Research Programs
- If the House and the Senate can agree on a budget that will reduce spending by $1.5 trillion over the next 10 years, the sequestration goes away.
AOTA’s Federal Legislative Agenda: Medicare

• Therapy Cap

• SGR Fix/Payment Reform

• Changes to Coding
  • AMA process underway
  • AOTA is key participant
  • Better describe OT to communicate better understanding of OT
  • Use ICF language and concepts
HR 713/ S 367 Access to Medicare Rehabilitative Services: Therapy Cap

• Introduced by Reps Gerlach (PA) and Becerra (CA) and Sens. Cardin and Cardin (MD) and Collins (ME);
• Arbitrary cap on outpatient therapy under Medicare set in 1999;
• $1900 per year for OT;
• We mobilized and advocated against the cap in 1999 and were successful in getting it put on moratorium and later to add an exception process;
• In addition to the exceptions process, there is now a manual medical review of claims in the top 5%, or over $3,700;
• Every year or two, we need to advocate to prevent the “hard cap” from being reinstated;
• Working on a long term solution.
Why Should Lawmakers Care about the Therapy Cap?

- If allowed to take effect, a hard cap on outpatient therapy services would be a blanket denial of to beneficiaries of much needed services.
- This is the only situation in Medicare where beneficiaries are arbitrarily denied services.
- Any fix to physician payments must include a fix to the Therapy Caps.
- Asking lawmakers to show their support for repeal of the cap by cosponsoring H.R. 713 or S. 367.
The Balanced Budget Act of 1997 called for annual adjustments to amount paid to doctors under Medicare; the Sustainable Growth Rate (SGR).

This is currently done by comparing the percentage increase in Medicare payments to doctors to the percentage increase in the GDP. This comparison is done at the beginning of each year using data from the previous year.

Based on a calculation that all admit is confusing, an adjustment is made to the payment amounts on March 1. However, Congress can delay implementation resulting in larger planned cuts.

Outpatient occupational therapy is paid under the Medicare Physician Fee Schedule.
The Sustainable Growth Rate, or SGR, is a major component of Medicare’s current formula for determining annual updates to physician reimbursements for services.

The SGR was intended to be a *budgetary restraint* on Medicare’s total expenditures to maintain budget neutrality.

Absent Congressional intervention, the SGR will dramatically cut physician reimbursement rates, while practice costs continue to rise.
SGR – On Sale Now!

• The Congressional Budget Office Released a New “Cost to Fix” the Sustainable Growth Rate (SGR):
  
  • $300 billion
  
  • $138 billion

If the SGR is going to get fixed, now is the time. If Physician Payments Change, so will Therapy payments.
New Developments: Proposed Medicare Payment Reform

- Two House Committees are considering ways to reform provider payments under Medicare.
- The draft proposal has four elements we must pay attention to:
  - Payment for quality/outcomes
  - Payment for efficiency of services
  - Payment for quality improvement (including adopting evidence-based practices)
  - Alternative Payment Models (i.e. Non-Fee for Service Models such as Medical Homes and ACOs)
- Even if the bill doesn’t pass: this is the direction of health care
AOTA Action on Possible Medicare Systems Change

- Comments on Committees draft proposals:
  - [http://www.aota.org/Practitioners/Advocacy/Federal/Testimony.aspx](http://www.aota.org/Practitioners/Advocacy/Federal/Testimony.aspx);
- Working with APTA and ASHA;
- Developing a New Coding Proposal with the AMA.
Question: Are there sufficient clinical practice improvement activities relevant to your specialty? If not does your organization have the capability to identify such activities and how long would it take?

- The Committee lists “the provision of care consistent with specialty-specific evidence-based guidelines” as an acceptable clinical improvement activity. AOTA has developed the following practice guidelines, which have been accepted (or are in the process of being accepted) into the Agency for Healthcare Research and Quality (AHRQ) clinical guideline database:
  - Adults with Neurodegenerative Diseases
  - Adults with Stroke
  - Adults with Traumatic Brain Injury
  - Driving and Community Mobility for Older Adults
  - Adults with Alzheimer’s Disease and Related Disorders
  - Adults with Serious Mental Illness
  - Productive Aging for Community Dwelling Older Adults
  - Older Adults with Low Vision (in press) and
  - Home Modifications (in development)
AOTA Looking Forward: Changes to Coding

- AOTA is working on a new coding system that would replace 15 minute codes with per-session codes.
- An improved coding system would better reflect services that are provided, which can lead to better tracking and outcomes data.
- The proposal includes three evaluation codes that describe different levels of patient severity and occupational therapist work complexity.
- In addition, six core codes would be used to describe the primary focus of an OT intervention during one session.
- The core intervention codes are based on terminology used in the International Classification of Functioning, Disability, and Health (ICF).
AOTA’s Federal Legislative Agenda: Mental Health

• “OT in Mental Health Act”: HR 1067

• Senate “Mental Health Awareness and Improvement Act”: S. 689

• President’s “Now is the Time” Gun Violence Proposal
Goal: Federal Recognition of Occupational Therapy as a Mental Health Profession in Federal Law

- Inclusion as a Mental and Behavioral Health Profession Under the National Health Services Corps:
  - Eligibility for loan forgiveness
  - Service to medically underserved areas
  - Critical Access Hospitals, Indian Health Service, Rural Health Clinics

- Recent CMS Conditions of Participation (COP) for Community Mental Health Centers - Sets Conditions to qualify for Medicare reimbursement
  - Access to interdisciplinary team including OT

- Strengthens advocacy arguments for additional federal and state policy changes.
- Still seeking a sponsor in the Senate, but expect introduction soon.
Mental Health Awareness and Improvement Act - Part of Gun Control Legislation

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<th>Within Schools</th>
<th>Within the Community</th>
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<td>• Provides opportunities for occupational therapy practitioners to expand their roles to be involved in school-based mental health programs through early intervening services and positive behavioral services and supports</td>
<td>• Promotes coordination with community-based mental health services therefore providing the opportunity for occupational therapist to play a key role in the coordination of behavioral and mental health care across settings</td>
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Mental Health Awareness and Improvement Act - continued

• This bill builds on the last reauthorization of the IDEA;
• Seeks to reduce the number of children identified for special education;
• Done through the promotion of school-wide initiatives for improving academic and behavioral outcomes for students;
• For the first time - Title 1 funds, (general education funds) can be used for Early Intervention Services (EIS) and Positive Behavioral and Intervention Supports (PBS).
• Inclusion of these programs into general education laws has been a core part of AOTA’s “Principals for Reauthorization of No Child Left Behind”.
Next Steps in Mental Health

• Introduction of Bill in Senate;
• Continue educating Members of Congress on the role of OT in mental health – meetings and briefings;
• Attempt to include NHSC language in other MH legislation moving through the House or Senate;
• Inclusion of OT in HRSA mental health workforce reauthorization;
• Inclusion of OT in NHSC appropriations bill. (Funding recommended by President’s Budget)
Medicare’s home health benefit under Part A serves only those who are "homebound," under the care of a physician, and need intermittent skilled nursing, physical therapy or speech therapy. Continuing occupational therapy may be provided upon referral. It is not a qualifying service to open a home health case.

- Bill to allow an occupational therapist to perform the initial and comprehensive assessment in Medicare Home Health with a doctor’s order;
- Not yet reintroduced in this Congress;
- Pursuing reintroduction and hope to have a bill soon.
AOTA Education Agenda

- **Individuals with Disabilities Education Act (IDEA)--- 2004**
  - Part B- School-based Practice
    - Early Intervening Services- (RtI, PBIS)
  - Part C- Early Intervention (Birth to Three)
    - Scope of Practice, Coordination, Child Find, Access, Costs, Reimbursement… New Regulations in 2011
  - Re-authorization overdue…

- **Elementary and Secondary Education Act (ESEA)/NCLB--- 2001**
  - Potential re-authorization in 2013 or 2014?
  - AOTA’s Principles for Reauthorization of ESEA

- **Higher Education Act (HEA)--- 2008**
  - Higher Education Opportunity Act
Part B- School-based Practice
  • Following Implementation of Early Intervening Services- (RtI, PBS, etc.)

Part C- Early Intervention (Birth to Three)
  • Scope of Practice, Coordination, Child Find, Access, Costs, Reimbursement…

• This bill was last rewritten in 2004 and is overdue for reauthorization.

• However, there is *no* talk of a new IDEA bill being brought up in this Congress.

• Continued focus on the Early Intervening portion of IDEA 2004.
School districts may use up to 15% of their IDEA funding to implement coordinated, early intervening services.

States that disproportionately identify students based on race or ethnicity as having a disability must use 15% of funds for EIS.

These services may not delay appropriate evaluation of a child suspected of having a disability.

Funds may be used for professional development and school-wide training.
• Reauthorization of No Child Left Behind is overdue;
• The last two Congresses have drafted proposals, but they have not gone anywhere;
• More recently the Obama Administration granted states “waivers” from the law;
• This has made reauthorization difficult as many states are now implementing their own plans;
• The Senate is considering an NCLB reauthorization in June that will most likely include Title I funds for Early Intervening Services;
• However, it is unclear that a final bill will pass this Congress.
Education Funding Issues: Medicaid

- Medicaid Expansion:
  - Not all states will participate in Medicaid expansion;
  - In those states that do, there will be a new population of children that qualify for Medicaid;
  - New “habilitation” benefits are supposed to be part of this Medicaid expansion;
  - Unclear how this new benefit will be implemented in each state, but we will continue to monitor;
  - Note, habilitation is a better fit with an “educational model” of OT compared to traditional rehabilitation benefits.
Under sequestration both Title I (general education) and IDEA funding has been cut by 5%;

The effect of these cuts on occupational therapy will vary from state to state, school district to school district:

- Has the state or district planned for these cuts already?
- What is the local and state economy like? Has the housing market (and tax base) begun to rebound?
- How committed is your district to Special Education and related services like occupational therapy – is it a priority?
Education Funding Issues: Cuts to IDEA

• #1 thing to advocate for is the preservation of OT services during tight funding times:
  – Show the value of your work with individual students and the school as a whole;
  – Make sure children are being referred when needed;
  – Advocate for reasonable caseloads/workloads.

• Cuts are going to come from somewhere, but remember, your services are required by law.
Bills Being Followed

Introduced - support:

• Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013 (H.R.942)
• Traumatic Brain Injury Reauthorization Act of 2013.
• Access to Frontline Health Care Act Act of 2013 (H.R.702)
Health Care Reform and Implications for Occupational Therapy Education

• Christina Metzler
  Chief Public Affairs Officer
• Brent Braveman, PhD, OTR/L, FAOTA
  AOTA Secretary and Chair, Ad Hoc Committee on Health Care Reform Implementation
• Assistance from Tim Nanof, Amy Lamb and the Ad Hoc Committee Members
Context For Health Care and Health Insurance Reform

- 47 Million Uninsured Americans
- 25 Million Underinsured
- Health Care Spending Rising
- Current Inefficiencies
- Denials and Rescission

Goals of the ACA:
Control Costs, Improve Quality, Improve Efficiency
The ACA

- Affordable Care Act (ACA) was signed into law March 2010.

- The law is intended to expand healthcare coverage to about 31 million uninsured Americans through a combination of cost controls, subsidies, and mandates.

- The law also includes ideas to change the current health care system to improve coordination and patient outcomes as well as to achieve savings.

- A primary aim of the legislation is to address what is referred to as the “triple aim” which includes 1) better health, 2) better health care, and 3) better value for the dollars spent.
A New System Structure?

- Affordable Care Act promoted many changes in both structures (delivery and payment) and services
- Changing system, payment structures
  - Medicare and Medicaid try-outs
  - Potential in private sector
- Changing services
  - Increased focus on preventative services
  - New areas of emphasis including primary care, chronic disease management and home based service delivery
Essential Health Benefits

(b) ESSENTIAL HEALTH BENEFITS.—
(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:
(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) 
Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.
“Habilitation Services – Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”
Minimum Parameters for Habilitation

• Coverage of habilitative services should be distinct from coverage of rehabilitative services
• Coverage should not be limited by age or medical condition
• Coverage requirements should explicitly mention the three core therapy services recognized by National Association of Insurance Commissioners (NAIC)
• The definition should be consistent with the NAIC and Medicaid definitions and include coverage of acquisition, retention, and improvement of function
• Availability of habilitative benefits should be based on determinations of need instead of arbitrary limits, but if quantitative limits are imposed, they should be separate from and at least at parity with those for rehabilitative services
Health Insurance Exchanges

• Health Insurance Exchanges will be created at the state level

• Individuals who do not have access to affordable employer-based coverage will be able to purchase coverage through a health insurance exchange at the state level.

• Small businesses could purchase coverage through a separate exchange.
What States Will Decide

• What insurance products will cover: benefits descriptions, medical necessity, limits, providers

• Prices of insurance
Health Insurance Exchanges

State Decisions For Creating Health Insurance Exchanges, as of May 10, 2013

Summary

Timeframe: as of May 10, 2013
Data View: Text
Locations: United States, States

Maine: Default to Federal Exchange

State Decisions For Creating Health Insurance Exchanges, as of May 10, 2013
Individual Mandate

• Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family) or 2.5% of household income, which will be phased in from 2014 to 2016.

• Penalties for large employers (more than 50) who do not offer insurance.
Employer Penalties

- If an applicable large employer does not offer minimum essential coverage to its full-time employees (and their dependents), the employer will be subject to a monthly penalty if any full-time employee receives subsidized coverage through an exchange. Generally, an employee may qualify for subsidized coverage through an exchange if his or her household income is less than 400 percent of the Federal Poverty Level (currently, that level is set at $88,200 per year for a family of four and $43,320 for an individual).
- The penalty for not offering coverage is generally equal to $2,000 for each full-time employee, not counting the first 30 full-time employees. Only full-time employees (not full-time equivalents) are counted for purposes of calculating the penalty. After 2014, the penalty amount may be indexed.
- The proposed rule allows an employer to satisfy the requirement to offer minimum essential coverage if the employer offers coverage to “substantially all” of its full-time employees (and their dependents), meaning it has offered coverage to 95 percent of its full-time employees and their dependents (or, if greater, to five employees). This does not alleviate the potential liability under the affordability prong, discussed below, to the extent one of the 5 percent not offered coverage receives subsidized coverage on the exchange.

https://www.aetna.com/health-reform-connection/questions-answers/employer-penalties.html#3
Lower than Expected Costs?


- “The Congressional Budget Office predicted back in November 2009 that a medium-cost plan on the health exchange – known as a “silver plan” – would have an annual premium of $5,200. A separate report from actuarial firm Milliman projected that, in California, the average silver plan would have a $450 monthly premium. Now we have California’s rates, and they appear to be significantly less expensive than what forecasters expected.”
### SILVER PLAN - 21 YR OLD

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### SILVER PLAN - 40 YR OLD

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Changes to Insurance Regulation

• No denials for pre-existing conditions including adults in 2014

• No recessions (declaring someone ineligible for coverage because of small mistakes made in the application process when they apply for benefits)

• No higher premiums on the basis of health status and gender.

• No lifetime limits on coverage effective 1/1/2014.

• Young adults will be able to remain on their parent’s health insurance until age 26.
Medicaid will be expanded to 133% of the Federal Poverty Level (in 2009, $14,404 for an individual $29,327 for a family of four) for all individuals age 65 or younger.
Medicaid Expansion April 2013

To Date, 20 States & DC Plan to Expand Medicaid Eligibility, 15 Will Not Expand, and the Remainder Are Undecided

State Commitment to Expand Medicaid Eligibility
Systems Changes Encouraged by the ACA

New Care Systems
New Payment Structures
Our Innovation Models

The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

Learn More >

Where Innovation is Happening

See where our Innovation Model Partners are located.

Select a State  Go There

Recent Milestones & Updates

- May 21, 2013
  Health Care Innovation Awards Announced: Health Care Innovation Awards Round Two Overview webinar. Learn More
The Accountable Care Organization (ACO) is a health care entity established by the Patient Protection and Affordable Care Act of 2010 (ACA).

- Integrated network of providers:
  - Hospitals, physicians, physician groups, private practitioners (occupational therapists and others)

- Work together:
  - To improve:
    - Individual and population level health outcomes
    - Coordination of care
  - Share accountability:
    - Quality
    - Cost
    - Outcomes
Accountable Care Organizations

• http://innovation.cms.gov/initiatives/ACO/

  – http://www.youtube.com/watch?feature=player_embedded&v=MZaa1QROQAU
Tracking Innovations Near You

Where Innovation is Happening

The Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. Additionally, Congress has defined, through the Affordable Care Act and previous legislation, a number of specific demonstrations to be conducted by CMS.

How to use this map: This map shows the Innovation Models run at the State level (in orange) as well as health care facilities where Innovation Models are being tested (in blue). In the default view of this map, all States and health care facilities of all Models are displayed. To create a filtered view, use the check-boxes to select the desired Models to display, and/or use the drop-down to go directly to a particular state or to zoom back out to the national view.

Select your Models to display

- Health Care Innovation Awards
- Incentives for the Prevention of Chronic Disease in Medicaid Demonstration
- Medicaid Emergency Psychiatric Demonstration
- Multi-payer Advanced Primary Care Program
- State Innovation Models Initiative: Model Design Awards
- State Innovation Models Initiative: Inaction

Display Selected

Models run at the State level:

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<th>Initiative Name</th>
<th>Organization Name</th>
<th>State</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Innovation Awards</td>
<td>Health Resources In Action</td>
<td>MA</td>
<td>Operating in Connecticut, Massachusetts, Rhode Island, Vermont</td>
</tr>
<tr>
<td>Health Care Innovation Awards</td>
<td>The National Health Care for the Homeless Council</td>
<td>MA</td>
<td>Operating in California, Florida, Illinois, Massachusetts, Nebraska, New York</td>
</tr>
</tbody>
</table>
Post-Acute Bundling Trials

- Single payment for all services related to a specific treatment or condition (e.g., a stroke), spanning multiple providers in multiple settings (RAND Corporation, 2011).

- Episode includes hospitalization; re-hospitalization; post acute care; and physician and other services, such as occupational therapy.

- 30 days post hospital

- Goal: Reduce costs, focus responsibility, prevent costly complications such as readmissions or hospital acquired infections
Post-Acute Bundling Trials

• What can occupational therapy practitioners contribute to organizations that are pursuing bundled payments?
Bundled Payment Trials

http://innovation.cms.gov/initiatives/Bundled-Payments/
Patient Centered Medical Homes

- The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system.

- While the term 'home' can often leave room for misinterpretation or confusion, we often emphasize that the "medical home" is not a place, but a philosophy of health and health care that encourages us to meet patients where they are, from the most simple to the most complex conditions. It is a place that should "feel like home" - where you are treated with respect, dignity, and compassion, and you have a strong and trusting relationship with providers and staff. It calls for a team care model that promotes accessibility, compassion, transparency, and is built on trust and communication. Its success is enhanced by health information technology and incentivized by smarter ways to pay for care.

http://www.pcpcc.net/about/medical-home
Medical Homes

• The core goal of the MH:
  – reduce fragmented care, improve efficiency and outcomes, and reduce overall costs

• Attributes of a MH in order to achieve the goal
  • **Patient centered**: organized around the patient’s core needs and includes education for self management
  • **Comprehensive**: covers the entire spectrum of patient needs including occupational therapy
  • **Coordinated**: through all levels of care including hospitals, office settings, home health, specialists services, and community services
  • **Accessible**: delivers accessible timely services including 24 hour a day telephone and electronic access to providers
  • **Quality and Safety**: committed to quality evidenced based medicine and measures outcomes on the patient experience and satisfaction
Patient-Centered Medical Home

• Pediatricians (AAP), Family Practitioners (AAFP), Physicians (ACP), Osteopaths (AOA)

• 2007 Agreement on Core Features
  – Personal Physician
  – Physician-Directed Medical Practice
  – Whole Person Orientation
  – Care Coordination and/or Integration
  – Quality and Safety
  – Enhanced Access and Communication
  – Payment
Implementation by 2014

- State exchanges established
- Plans identified
- Access to reasonable cost insurance
- Medicaid Expansions
- Medicare experiments, trials examined
- How will the states organize exchanges?
- Will the plans cover the essentials?
- Will medical necessity be defined validly?
- Will people respond and buy insurance?
- Will Congress change their mind?
Implications for OT

• Improve role in primary care team, medical homes, and ACOs.

• Increased involvement in prevention and wellness activities and interventions which save money.

• Protect OT in “rehabilitation and habilitation services” in mandatory benefits package.

• Inclusion of mental health and substance abuse disorder services, including “behavioral health treatment,” as a required category in the mandatory essential benefits package.
Challenges

• Other disciplines establishing themselves as key players in rehabilitation, habilitation, mental health, prevention and wellness, chronic illness management, and long term care.

• Occupational Therapy must move forward and educational programs will play a critical role in preparing practitioners to adopt new roles and provide key services.
Current Directions to Achieve Triple Aim with Implications for OT Education

• Centralize Responsibility for Patients’ Care and Health (e.g. ACO’s)
• Improve Ways Care is Provided (e.g. medical homes)
• Address Comprehensive Need
• Address Patient-Controlled Aspects
  – Home Situation
  – Self-Management
  – Choices
Implications for Occupational Therapy Within an ACO and Medical Home

• All providers, including OT, responsible for high quality, patient centered, evidence-based care at reduced cost.

• Possible Roles:
  • Screening for functional deficits upon entrance
  • Addressing function and safety during discharge planning to prevent re-hospitalization
  • Managing care for chronic conditions to promote self-management
  • Screening and prevention in areas such as falls
  • Wellness interventions that will help achieve quality outcomes at reduced cost
Occupational Therapy
...a Perfect Fit in the ACO and Medical Home System

What can practitioners do to Make OT an Integral Part of this System?

• Gather effectiveness literature to advocate for OT’s inclusion in the full spectrum of patient care management

• Participate in ACO and MH planning and offer information on how OTs can be an effective team member

• Participate in your facilities electronic medical records system development and ensure that the purpose and language of OT is included

• If your facility is providing coordinated care across settings it will likely be one of the first to be involved with an ACO. Talk to your administrator and offer to be involved in the implementation process
Prevention: Cost Effective Strategy to Improve Health

- Partnerships in prevention
- Ensure that prevention-focused health care and community prevention efforts are available
- Empower people to make healthier choices.
- Eliminate health disparities and improve quality of life for all Americans.
How Occupational Therapy Fits In

Traditional Healthcare
• Evaluation of risk for hospital acquired conditions
• Pre discharge OT eval (e.g., in home)
• Home assessments and modifications
• Lymphedema management
• Self-management for clients with chronic disease
• Fall prevention
• Implementation of depression screening programs

Education Settings
• Backpack awareness
• Healthy use of technology such as computers and tablets (iPads)
• Bullying education
• Obesity prevention
• Afterschool empowerment groups – stress management, coping skills, healthy living
• Mock job interviews with student
• Supported education programs in higher education
How Occupational Therapy Fits In

**Communities**
- Fall prevention partnerships
- Caregiver training and support
- Aging-in-place programs for seniors
- Elder care management
- Conduct research with mental health agencies and stakeholders to reduce health-related disparities and early mortality
- Build collaborative partnerships with agencies focused on improving health equity of at-risk populations

**Employers**
- Injury prevention training
- Promote emotional wellbeing through training on balance in work, leisure and family life
- Ergonomic assessment and intervention
- Body mechanics training for personnel
- Supported employment programs
Chronic Disease Management

• According to the ACA, Chronic Disease Management is a
  
  – Benefit provided by health plans and Medicaid
    • Included as an essential benefit.
  
  – Service provided by health care providers, health plans and/or community networks
    • Incentivizes states to develop primary care-centered medical homes for Medicaid enrollees with chronic conditions.
    • Directs the Center for Medicare and Medicaid Innovations to focus on developing models for care coordination for CDM.
    • Incentivizes states to develop primary care medical homes for Medicaid enrollees with chronic conditions.
  
  – Outcome of benefits and services
    • Requires health plans to report CDM as an indicator of the quality of care by 2012.

Carol Seibert, AOTA Ad Hoc Committee
Multiple Chronic Conditions (MCC)

- One in four Americans have MCC
- 2 of 3 Medicare beneficiaries have MCC
- 66% of total healthcare spending is associated with care for those with MCC

“The confluence of MCC and functional limitations, especially the need for assistance with activities of daily living, produces high levels of spending. Functional limitations can often complicate access to health care, interfere with self-management, and necessitate reliance on caregivers.” (USDHHS, 2010)

- New initiatives
  - HHS Initiative on MCC: [http://www.hhs.gov/ash/initiatives/mcc/](http://www.hhs.gov/ash/initiatives/mcc/)
  - NQF MCC Measurement Framework: [http://www.qualityforum.org/Projects/Multiple_Chronic_Conditions_Measurement_Framework.aspx](http://www.qualityforum.org/Projects/Multiple_Chronic_Conditions_Measurement_Framework.aspx)

- Implications for OT: $1 + 1 \neq 2$ Addressing functional limitations can support health & independence and reduce costs for those with MCC

Carol Seibert, AOTA Ad Hoc Committee
Specifically, the ACA...

- Requires health plans to report chronic disease management as an indicator of the quality of care by 2012.
- Chronic disease management is included as an essential benefit.
- Directs the Center for Medicare and Medicaid Innovations to focus on developing models for care coordination, etc.
- Incentivizes states to develop primary care-centered medical homes for Medicaid enrollees with chronic conditions.
- Recognizes a program of community-based, interdisciplinary professional teams to help primary care practices develop more effective systems for managing health problems, including chronic conditions.
What does that translate to?

• (Self) care of a chronic condition (or multiple chronic conditions) involves activities of daily living
• Activities of Daily Living **ARE** OT
• How do we convince the system?
Chronic disease (or condition) management has two components

1. Care provided by health professionals
2. Self-care provided by those with the condition (or their caregivers)

Self management:

– 90% of the management of a chronic disease must come from the person who has the disease. (California Healthcare Foundation, 2008)
– (Self) care of a chronic condition (or multiple chronic conditions) involves daily living activities.

Carol Seibert, AOTA Ad Hoc Committee
Chronic Disease Management in Existing OT Roles

• Addressing disease management aspects of ADLs and IADLs as part of OT care plans, including:
  – Medication management
  – Self monitoring tasks: weight, blood pressure, blood glucose
  – Incorporating dietary recommendations into meals, meal preparation and grocery shopping
  – Diabetic foot care
• Energy conservation/task simplification
• Incorporating disease management into existing habits and routines

Carol Seibert, AOTA Ad Hoc Committee
Chronic Disease Management in Emerging OT Roles

- OT in primary care teams specifically addressing chronic disease management
- Specialty disease management teams
- Case management/care management
  - Within community networks
  - Within ACOs and medical homes
  - Within or contracted to payer organizations
  - Direct referrals from primary care for secondary and tertiary prevention

Carol Seibert, AOTA Ad Hoc Committee
Possibilities for OT

• OT in “primary” care
  – Inclusive not adjunct

• OT at critical “cost” points
  – Discharge
  – New Medication
  – New Diagnosis
  – New Context
  – Improper use of care (e.g., ER overuse)

• OT as powerful
  – Backed by research
  – Taking on/creating new roles
Primary Care

- Primary care is defined as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (PL 111-148)
“The Obama Administration believes that strengthening and growing our primary care workforce is critical to reforming the nation’s health care system. Increasing access to primary care physicians and nurses can help prevent disease and illness and ensure all Americans – regardless of where they live – have access to high quality care.” www.healthcare reform.gov

- $25 billion+ through ACA to train and support traditional primary care providers and practices
Skills for the OT in Primary Care

- Competent across the age spectrum
- A true “Generalist” - broad experience & skills
- OTs practicing with a specialized population could be the primary provider for that population (like ALS, hands, and primary care)
- Knowledgeable about our scope of practice
- Able to think on one’s feet and think outside the box
- Able to self-advocate
- Ethically sound

Sherry Muir, St Louis University
Top Areas that Evidence Supports OT Evaluation and Intervention within Primary Care

- Pediatric
  - Developmental Interventions
  - Sensory Integration

- Upper Extremity Rehabilitation
  - Orthotic Interventions
  - Soft Tissue Management (Lymphedema, Circulation, Wounds, Edema, Tissue Balance)

- Mental Health
  - Internal Locus of Control (Empowering)
    - Anxiety and Depression
    - Stress
    - Pain
Top Areas that Evidence Supports OT Evaluation and Intervention within Primary Care

• Basic Activities of Daily Living/Instrumental Activities of Daily Living
  
  Compensatory Techniques/Self-care Modification
  – Adaptive Equipment
  – Work Place Modification
  – Ergonomics
  – Positioning: Work, Sleep, Seating
  – Joint Protection
  – Energy Conservation
  – Fall Prevention
  – Community Participation
  – Medication Management
  – Vision Management

• Patient Activation and Engagement
  – Chronic Care Management (e.g. diabetes management, weight management, mental illness, etc.)
Telehealth

- The use of telehealth to support OTs role in primary health care and client-centered health teams
- Telehealth reimbursement and opportunities to advocate for OT
- Licensure/practice act telehealth language
- Opportunities to work with other rehabilitation professional associations and regulatory boards on licensure portability
- Need for stakeholder (i.e. practitioners, legislators, reimbursement entities) education on telehealth/OT and ways to meet these educational needs
There are now 19 states (vs. 16) mandating private insurance to cover services provided through telehealth if those same services would be reimbursed when provided in-person (http://www.americantelemed.org/docs/default-source/policy/state-telemedicine-legislation-matrix.pdf?sfvrsn=50)
Telehealth

- AOTA vendor booth at the 2013 American Telemedicine Association’s International Meeting & Expo (May 5-7; Austin, TX)
- Will be present along with ASHA and APTA at 2014 ATA conference in Baltimore MD
- Worked with the Commission on Practice on the new AOTA Telehealth Position Paper (2013)
- Co-chaired ATA’s License Portability Sub-Committee (with participation from AOTA and representatives of professional associations and regulatory boards of OT, PT, SLP, and Audiology)
Moving Forward

- Analyze
- Educate
- Strategize

- We need to triage where OT fits into the systems problems

- Legitimacy
- Credibility
- Continuity
Creative Insight

Patience

Sensitivity

Focus

Vision

Versatility

CHANGE
Take Action!

- **1) PARTICIPATE:** Be an AOTA & state OT association member so there is greater support for legislative action

- **2) ADVOCATE:** Grass roots communications by members to their senators and representatives – call, write, email or visit

- **3) CONTRIBUTE:** Donate to AOTPAC so we can elect and retain legislators who support our priorities

P*A*C
Environmental Scanning

- America’s Health Insurance Providers Smartbrief
  - https://www.smartbrief.com/ahip/index.jsp
- The Advisory Board Company (daily briefing)
  - http://www.advisory.com/Members/Register
- White House Weekly Update
  - http://www.whitehouse.gov/weekly-health-care-update
Issues & Advocacy

Federal and state legislative issues affect you—where you practice, what you are paid, whether you practice at all. It's your profession, your future...so read, understand, and take action. Use this information to help you protect your profession and your future.

Health Care Reform Implementation

Advocacy Tools & Resources

State Advocacy

Federal Advocacy

AOTPAC

Capitol Hill Day 2012

Reimbursement

Resources

- Want To Do Advocacy? There’s Something for Everyone

- Listen to a Podcast on How To Advocate with Specifics and Examples from Basic to More Complex

- Tips on Meeting With Your Legislators

- Legislative Action Center
Other Resources

- Kaiser Family Foundation  
- RAND Corporation  
- Health Affairs  
- Politico  
AOTA’s Legislative Action Center

http://capwiz.com/aota/home
AOTA Capitol Hill Day 2013

Join over 500 occupational practitioners and students from around the country in Washington D.C.

Monday, September 30th 2013
8:30am
A Call to Action: Responding to the Evolving Practice Context

• Things you can do:
  – Talk about health care, health insurance and health policy reform at meetings
  – Actively scan your environment, sign up for just 1 news or Email source
  – Attend organizational town halls and meetings
    • Be prepared to identify yourself as an occupational therapy practitioner
    • Make 1 comment about the role of the OTP in new roles
    • Be prepared with 1 question
  – Develop a relationship with your Senators and Representatives
    • Schedule an office visit
    • Send an Email on 1 critical issue
A Call to Action: Responding to the Evolving Practice Context

• Exercise
  – At your tables
    • Identify a skill you believe practitioners need to thrive in the evolving health care arena
    • What can you do in your fieldwork settings to foster the development of this skill in students and clinical fieldwork educators
  – Example: more sophisticated screening skills for complex medical disorders such as early signs of diabetes
  – Development of e-learning modules on most commonly seen conditions including signs, symptoms, simple prevention and steps to refer patients to other members of the medical team.
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