Health Care Reform Implementation and State Health Policy

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ALOTA 2017 Fall Conference
Orange Beach, Alabama
September 23, 2017
8:00am – 9:00am

Objectives

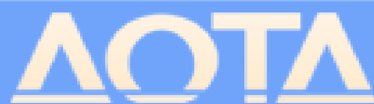
- Recognize policy issues at the state level that impact the profession
- Identify the key policy issues that have impacted occupational therapy as the ACA was implemented
- Understand current legislative proposals to reform the insurance market and Medicaid

State Policy Issues

- State Regulation of Occupational Therapy
- Scope of Practice challenges
- Fair co-pay legislation
- Autism mandates
- Telehealth

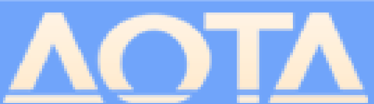
State Regulation of OT

- Full implementation of licensure laws; guard against sunset
- Deregulation proposals or regulatory board consolidation (e.g., for budget reasons)
- Revisions to OT regulations (supervision, code of ethics, continuing competence requirements, etc…)
- License portability
- Definition of "occupational therapy practice"
- Telehealth



Scope of Practice

- A body of knowledge historically included in the educational preparation of the discipline,
- A clearly established history of application in practice as reflected in professional literature, and
- The legal framework created by state practice acts or licensure laws.
- AOTA model practice act includes model definition of OT practice
- Based on *OT Practice Framework*
- Most recent revisions made to the model definition of OT were in 2014. Last major revision was in 2011.



Scope Challenges

These initiatives fall primarily into two broad categories:

(1) broadening another profession's scope of practice in such a way as to impact the domain of occupational therapy practice; and

(2) establishing new policies that inappropriately prevent occupational therapy practitioners from practicing within their scope of practice.

Fair Copay

Occupational Therapy Fair Cost-Sharing Laws

Enacted	State	Services Covered	Scope of Limitation
2011	Kentucky	Occupational therapy (OT) and physical therapy (PT)	The copay and coinsurance may not exceed the amount charged by the physician or osteopath.
2012	South Dakota	OT, PT, and chiropractic	The copay and coinsurance may not exceed the amount charged by the primary care physician.
2013	Arkansas	OT, PT, and speech-language pathology	The copay, coinsurance, and deductible may not exceed the amount charged by the primary care physician or osteopath.
2014	Tennessee	OT, PT, and chiropractic	The copay and coinsurance may not exceed the amount charged by the primary care physician.
2014	Connecticut	OT and PT (2013)	The copay may not exceed $30 per visit.

Recent Legislation

- Colorado - study
- Iowa – enacted 2015
- Missouri – enacted 2016
- New Mexico
- Pennsylvania – enacted 2015
- Washington State – final bill address prior authorization

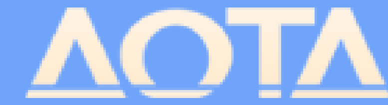
Telehealth

Occupational Therapy and Telehealth

State Statutes, Regulations and Regulatory Board Statements

State	Authority	Citation and Provisions[1]	Notes
AL			No statute or regulations specific to OT and telehealth, but Board reports that current laws and regulations allow for the practice of telehealth
AK	Regulation	12 AAC 54.825. STANDARDS FOR PRACTICE OF TELEREHABILITATION BY OCCUPATIONAL THERAPIST. (a) The purpose of this section is to establish standards for the practice of telerehabilitation by means of an interactive telecommunication system by an occupational therapist licensed under AS 08.84 and this chapter in order to provide occupational therapy to patients who are located at distant sites in the state which are not in close proximity of an occupational therapist. (b) An occupational therapist licensed under AS 08.84 and this chapter conducting telerehabilitation by means of an interactive telecommunication system (1) must be physically present in the state while performing telerehabilitation under this section; (2) must interact with the patient maintaining the same ethical conduct and integrity required under 12 AAC 54.800; (3) must comply with the requirements of 12 AAC 54.810 for any licensed occupational therapist assistant providing services under this section; (4) may conduct one-on-one consultations, including initial evaluation, under this section; and (5) must provide and ensure appropriate client confidentiality and HIPAA compliance, establish secure connections, activate firewalls, and encrypt confidential information.	
AZ			No statute or regulations specific to OT and telehealth, Board reports it does not have the authority to determine position

http://www.aota.org/Advocacy-Policy/State-Policy.aspx



ACA Principles

- Near-universal coverage through Medicaid expansion and new, subsidized health insurance marketplaces
- Encouraging state-level innovation (e.g. state-based marketplaces, State Innovation Waivers)
- Bending the cost curve through payment and delivery system innovations

How did the ACA change the individual and small group markets?

- Prohibited insurance companies from rejecting applicants, or charging them more, because of pre-existing conditions
- Guaranteed a set of 10 essential health benefits (EHBs)
- Banned annual and lifetime dollar limits on EHBs
- Capped annual out of pocket costs (co-payments, co-insurance, deductibles) for the EHBs
- Required plans to adhere to fixed levels of coverage that guarantee the percentage of total costs that will be paid by the plan rather than the policy holder (metal levels)

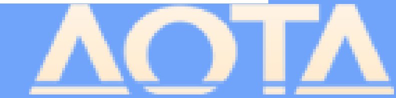
Types of ACA Marketplaces

State Health Insurance Marketplace Types, 2017: Marketplace Type, 2017

WA MT ND MN ME
OR ID SD WI MI VT NH NY MA RI CT
WY NE IA IL IN OH PA NJ DE MD DC
NV UT CO KS MO KY WV VA
CA AZ NM OK AR TN NC SC
MS AL GA TX LA FL
AK HI

- Federally-facilitated Marketplace
- State-based Marketplace
- State-based Marketplace-Federal Platform
- State-Partnership Marketplace

SOURCE: Kaiser Family Foundation's State Health Facts.

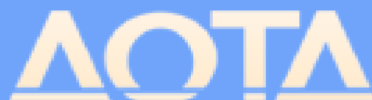


How did the ACA affect the uninsured rate?

- Last year the uninsured rate hit an all-time low:
  - In 2016, 8.8% (28.1 million) were uninsured
  - That's 20.5 million fewer than when the ACA was enacted

What to expect for open enrollment?

- Average premium increases: 20%
  - Wide variation across/within states
- Fewer choices as insurers exit the individual market
  - In danger of "bare counties"
- Instability largely due to cost-sharing reduction (CSR) payment uncertainty and individual mandate enforcement



What are “essential health benefits?”

Complete list of EHBs in the Affordable Care Act

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Source of image: http://modernmedicines.com/small_essential_health_benefits.png

What's the difference between habilitation and rehabilitation?

Habilitation vs. Rehabilitation

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.

Rehabilitation Services

Health care services that help a person **keep, get back or improve** skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

A uniform definition of habilitative services

§ 156.115 Provision of EHB.

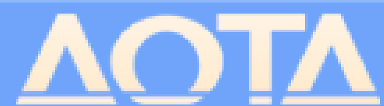
(a) * * *

(5) With respect to habilitative services and devices—

(i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not 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;

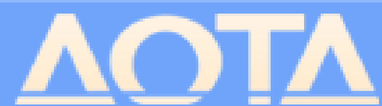
(ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and

(iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices.



OT in the SBC

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits/year
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 visits/calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	Not covered	Coverage limited to one exam/year.
	Children's glasses	20% coinsurance	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	Not covered	None

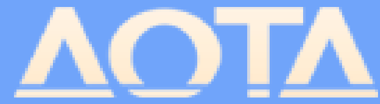


Medicaid Expansion Map

Current Status of State Medicaid Expansion Decisions

- Adopted (32 States including DC)
- Not Adopting At This Time (19 States)

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/



What's the state of Medicaid expansion?

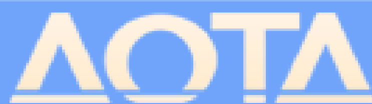
- Thanks to the Supreme Court, states got a choice
- This year states get a 95% federal match for the expansion population
  - Will phase down to 90% in 2020 and thereafter
- Among the 31 states (and DC) that have expanded:
  - Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire have used Section 1115 demonstration waivers

Administrative actions can repair the ACA – or destroy it

- President's executive order on day one: "waive, defer, grant exemptions from [and] delay implementation of" burdensome ACA regulations
  - IRS actions to relax enforcement of individual mandate
- HHS/CMS calling on governors to seek waivers to ACA Marketplace and Medicaid rules
- The administration has not promised to keep paying the CSRs this year; now month-to-month
- Congress has not promised to appropriate money for CSRs in the future

What are 1332 waivers?

- The ACA created 1332 waivers to allow states to develop alternative approaches to meeting the coverage goals of the ACA
  - Hawaii (December 2016) and Alaska (July 2017)
- HHS has encouraged ideas like high risk pools, reinsurance, and other innovations to stabilize the risk pools
- States could waive EHBs and other central elements of the ACA



What are 1115 waivers?

- Demonstration waivers that have been around longer than Medicaid itself
- 1115 waivers have been used to do "experimental" Medicaid expansions
  - The new head of CMS helped design Indiana's first-of-its-kind waiver
- HHS Sec and CMS Admin letter to governors suggested CMS would approve work requirements
- Want to apply concepts from expansion waivers to the entire program

“Repeal and Replace” Timeline

- 1st day of new Congress: 2017 budget resolution with reconciliation instructions
- American Health Care Act (AHCA)
  - Passed the House May 4, 2017
- Better Care Reconciliation Act (BCRA)
  - Failed to pass the Senate July 27, 2017
- Graham-Cassidy introduced mid-September
- Sept 30: 2017 budget resolution expires

Market Stabilization

- Series of Senate HELP Committee hearing, September 2017 seeking bipartisan fixes, discussed:
  - Years-long appropriation for CSR payments
  - Federal reinsurance program
  - Making 1332 waivers easier to get
  - Funding outreach & enrollment assistance
  - Making catastrophic plans widely available
- Talks broke down after Graham-Cassidy intro

Graham-Cassidy-Heller-Johnson

- Caps Medicaid

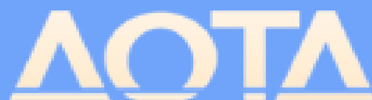
- Replaces ACA marketplaces and Medicaid expansion with a temporary block grant

Graham-Cassidy and Medicaid

- The ACA expanded Medicaid eligibility to all individuals up to 138% of poverty
- Graham-Cassidy would fundamentally restructure *all of Medicaid* by changing it from an open-ended entitlement to a capped program
  - Per capita cap
  - Block grant
- Allows states to impose work requirements

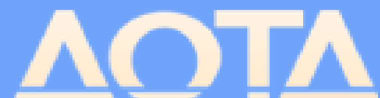
What is a per capita cap?

- The federal government would contribute a set amount per beneficiary starting in 2020
- Separate caps or allotments for five categories of beneficiaries:
  - Elderly
  - Disabled
  - Children
  - Adults
- Capped amounts would grow more slowly than under current law



What is a block grant?

- States would have the option of selecting a block grant instead of a per capita cap for a portion of their federal Medicaid funding
- Block grants permitted for non-elderly, non-disabled adults
- Free from most federal requirements, including:
  - EPSDT
  - Statewideness
  - Amount, duration, and scope
  - Free choice of provider

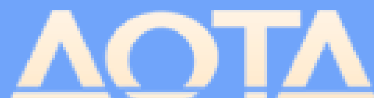


Graham-Cassidy and Obamacare

- A truer "repeal" than the House and previous Senate health care bills
- Repeals individual/employer mandates
- Repeals Medicaid expansion
- Repeals ACA marketplaces and federal subsidies for low-income enrollees
  - Tax credits & CSRs

Graham-Cassidy's Block Grants

- Replaces Medicaid expansion and subsidized marketplaces with block grant
- Block grant redistributes federal funds among the states
  - Away from states getting more federal $ now because of Medicaid expansion and/or high marketplace enrollment
- Around $1.2 trillion over 7 years (2020-2026)
  - 2027 and beyond = ?

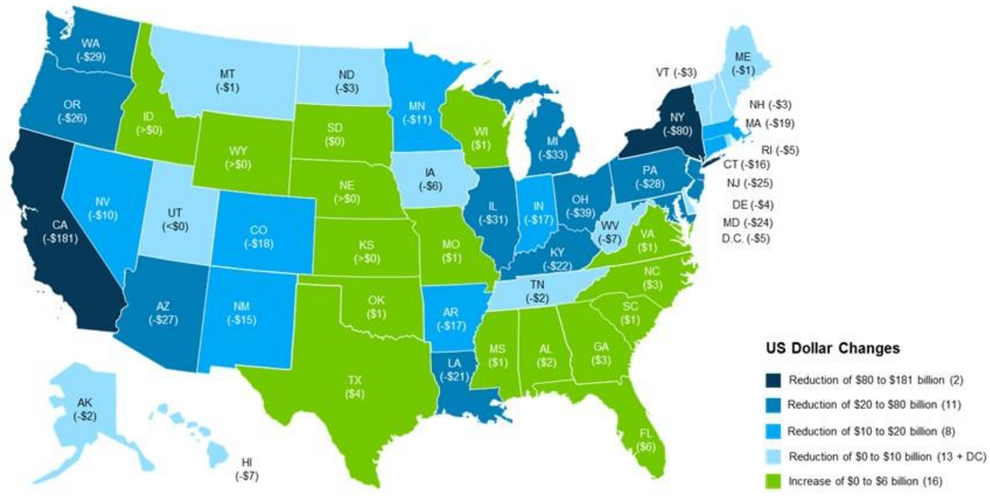


Medicaid Funding

Press Release

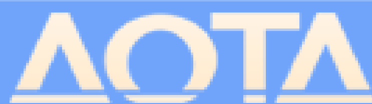
Graham-Cassidy-Heller-Johnson Bill Would Reduce Medicaid Funds to States by $713B Over the Next 10 Years

Chris Sloan, Richard Kane | Sep 22, 2017



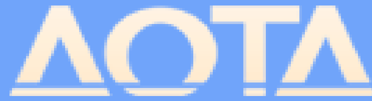
Source:

http://avalere.com/expertise/managed-care/insights/graham-cassidy-heller-johnson-bill-would-reduce-medicaid-funds-to-states-by



Potential Impact

- Will insurance and Medicaid cover OT?
- What will happen to hospitals? Do you work in an acute or rehabilitation hospital?
- Will children be affected? Do you work in schools?
- Are you concerned about discrimination?
- What will happen to the insurance market? What will happen to your own health insurance?



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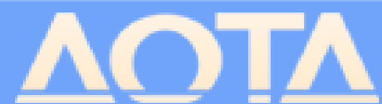
Health Care Reform Implementation

State Policy

Health Care Reform Efforts Revived in the Senate

Heather Parsons
9/21/2017

Last week efforts to repeal the Affordable Care Act were suddenly revitalized with the introduction of the Graham-Cassidy-Heller-Johnson bill (Graham-Cassidy) in the Senate. Like the Better Care Reconciliation Act before it, the American Occupational Therapy Association (AOTA) has grave concerns about Graham-Cassidy. In particular, we are concerned about restructuring the Medicaid program, waiver of essential health benefits, and a roll-back of protections for people with pre-existing health conditions. You can read the article by AOTA “Health Care Still in Flux” for more details on the bill. Because of the concerns mentioned above, AOTA opposes the Graham-Cassidy bill. The Senate Finance Committee is expected to hold a hearing on the legislation next Monday at 2:00 p.m. ET and a vote on the Senate floor could be held anytime next week.



Q & A

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