The Role of Physical Therapy in Health Care Reform

MN APTA Fall Conference
October 7, 2011
Duluth, Minnesota

What we don’t know, might hurt us

WHAT IS YOUR MOTIVATION TO ATTEND?

- Are you worried about the impact of reform on your practice in your setting?
- Are you confused about the whole issue of health care reform?
- Does reform pose an opportunity or threat to your setting or the way you practice?

“Critical Thinking” that leads to “Change”

STOP
LISTEN
THINK
The Role of Physical Therapy in Health Care Reform

Kick off a two year strategic project: “The Role of Physical Therapy in Minnesota in Health Care Reform”

Triple Aim: How do therapists demonstrate value to patients and other providers?

Present various payment models for physical therapy services as proposed in health care reform

How will payment effect the care delivered by physical therapists and assistants?

Provide an overview of the role of physical therapists and physical therapist assistants.

What role should therapists and assistants play in a new health care delivery model?

Serles Objectives

1. To critically assess the opportunities and threats to the future of physical therapy brought on by the implementation of health care reform.
2. To envision and communicate the role of physical therapy in a new health care delivery model that demonstrates the value of physical therapists and assistants.
3. To become a leader of change for a cost-effective, quality driven, evidence based, and coordinated delivery system within your practice or organization.
Position Statement on Health Care Reform

2011 Fall:
Gather input from this group and other members on health care reform.
Panel to recommend language to MN APTA Board in November.

2012 Spring:
Present to members for adoption the MN APTA position on health care reform.

2013 Spring:
Present to members for adoption the MN APTA position on specific aspects of health care reform.

Health Care Reform Panel
- Craig Johnson: Therapy Partners, Inc., Director of Clinical Integration
- Tim Adams: Minnesota Chapter of APTA, Executive Director
- Joan Bohmert: Anoka–Hennepin School District, Director of Rehab Services
- Diana Nowatzki: Fairview Health Systems, System Director for Rehabilitation
- Kathleen Picard: OSI Physical Therapy, Inc., Director of Business Development
- Erin Simunds: Courage Center, Director
- Jessica Solberg: PTA. St. Catherine University, Faculty Assistant in the Doctor of Physical Therapy and Physical Therapist Assistant Program
- Pat Tarnowski: Allina Health Systems, Director of Sister Kenny Rehab Institute

MN APTA Board of Directors
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- Pat Tarnowski, Director
- Barb Wiegand, Director

Course Objectives
1. Understand the main elements of federal and state legislation that is the legal blueprint for health care reform.
2. Define the elements of the Triple Aim and its importance in health care reform
3. Identify the opportunities and challenges for your specific setting.
4. Be better prepared to engage in changes within the work place through a better understanding of health care reform.
Health care reform is change in health policy that affects health care delivery, quality measures, and reimbursement for health care services.

- Reform pushed towards delivering higher quality care in an affordable model
- Restructure health care delivery methods and how this care will be reimbursed

**Triple Aim**

- Patient Experience
- Decreased Cost
- Quality Outcome

**Now and Then**

<table>
<thead>
<tr>
<th>Now</th>
<th>Post reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do more</td>
<td>Do the right thing at the right time in the right place</td>
</tr>
<tr>
<td>Unassigned patients</td>
<td>Attributed population care</td>
</tr>
<tr>
<td>Reactive episode</td>
<td>Proactive intervention</td>
</tr>
<tr>
<td>Pay for procedure</td>
<td>Pay for quality</td>
</tr>
<tr>
<td>Charge based</td>
<td>Value based</td>
</tr>
</tbody>
</table>
**Why? – Top Drivers of Reform**

- Insufficient outcomes for dollars spent
  - Poor outcomes – infant mortality, longevity
- Uncontrolled costs
  - Waste
  - Variable care
  - Overutilization
- Rising numbers of uninsured
- Demographics – aging population with growing needs
- Poor management of chronic care needs
- Lack of access to care

**Who Determines Health Care Policy**

- Federal legislation
  - Medicare
- State legislation
  - Medical Assistance
- Private Insurance Payers
- Managed Care Payers

**Spending**

<table>
<thead>
<tr>
<th>Age</th>
<th>Mean Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18-44</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>Age 45-64</td>
<td>$8,000.00</td>
</tr>
<tr>
<td>Ages 65+</td>
<td>$12,000.00</td>
</tr>
</tbody>
</table>

National Center for Health Care Statistics 2011

**Health Care Reform at the Federal Level (Legislation)**

- The Patient Protection and Affordable Care Act (PPACA) of 2010 (HR 3590) – Public Law 111–148
  - Signed by Barack Obama March 23, 2010
- Health Care Reconciliation Act of Public Law 111–1522010
  - Signed by President Barack Obama on March 30, 2010
  - Cost is 1 Trillion dollars in new spending
Children can stay on their parents insurance plan until age 26.

- Children cannot be excluded from coverage if they have pre-existing condition.
- High risk plans available for adults with preexisting conditions.
- End to lifetime limits of care with catastrophic illness – end of caps.
- No deductibles for preventative services including immunizations and screenings.
- $250 tax rebate if you are over 65 on Medicare Part D and hit the doughnut hole for pharmacy coverage.

Increased funding for investigation of fraud by 325 million over 10 years:

- Medicare, Medicaid, CHIP
- 2012 bring Medical Assistance RAC audits
- Recovery audit contractors (RAC) – paid % of what they identify as overpayment
- 2.9 billion returned to the Medicare Trust Fund in 2009

PPS SNF October 2010, 2011:
- Shift of reimbursement from rehab minutes to medical complexity
- Reduced reimbursement for concurrent therapy, bill for therapists time only
- Multiple procedure payment reduction
- 20% in private practice, 25% reduction in hospitals for billing of more than one therapy procedure per day.
2011

- Medicare initiate free preventative care – included are annual wellness provider checkups
- Medical Assistance (Minnesota) expanded to include individuals who don’t have children and are 75% below the poverty level
- Medicare implements physician compare website launch

2011

- Hospital Readmissions Penalties
  - Reduction in reimbursement
  - Adjusts payments for hospitals paid under the inpatient prospective payment system, based on % preventable hospital readmissions

Health Care Home

Also known as
- Patient centered medical home
- Medical home
- An approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities

Health Care Home

- Envisions accessible, continuous, patient-oriented, team-based, and comprehensive care delivered in the context of a patient’s family and community.  
  (Bitton, 2010)
- The goal will be achieved through practice transformation supported by external payment reform designed to support the delivery of enhanced primary care services.  
  (Bitton, 2010)
Health Care Home

**Components**
- Primary care providers (physicians, physician assistants, and nurse practitioners) with a focus on staff practicing at the top of their license
- Most HCIs are focused on a single diagnosis or population group – asthma, homeless, medically fragile pediatrics
- Care coordination addressing medical and social concerns is a part of the model
- A team approach to care, including clients, care providers, and families.
- Use of conditions registries to manage population health
- Clients must have at least one chronic condition

Meaningful Use of the Electronic Health Care Record

- First regulation effective October 1, 2011
- The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information.
- Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and, most importantly, improve the quality of care

State 2011 Legislative Changes to Medical Assistance

- September 1, 2011 – June 30, 2015
  - 10% reduction on inpatient adult acute hosp rates
  - July 2015 a 1% increase for every 1% reduction in hosp re-admission rate for the established base line to a max of 5%
- January 1, 2012
  - Elimination of specialized maintenance therapy, PT, OT, SLP
- March 1, 2012
  - Prior authorization required for all PT, OT, SLP services

2012

Accountable Health Care Organizations
- Definition = group of providers working together to manage and coordinate care
- Shared accountability for quality and cost
- CMS requires application and a minimum of 5000 Medicare Beneficiaries
- Medicare initiates January 1, 2012 for provider organizations meeting the programs quality, volume, and administrative requirements
- Assumes accountability for a panel of patients care over a period of time
  - Improve quality
  - Reduce costs
  - Increase value
- Apply through a formal process to the Centers for Medicare and Medicaid Services
- Must implement practices based on the three part aim.
**CMS ACO Requirements**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub Category</th>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>Communication with Doctors</td>
<td>7</td>
<td>HCAHPS</td>
</tr>
<tr>
<td></td>
<td>Communication with Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication about Medication</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Responsiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overall Rating of Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Electronic Health Care Record</td>
<td>16</td>
<td>Clinical Data</td>
</tr>
<tr>
<td></td>
<td>Care Transitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Acquired infection</td>
<td>2</td>
<td>Claims</td>
</tr>
<tr>
<td></td>
<td>Medication errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Health</td>
<td></td>
<td>9</td>
<td>Clinical Data</td>
</tr>
<tr>
<td>Chronic Care At Risk Population</td>
<td>Re-admission</td>
<td>31</td>
<td>Claims/Clinical Data</td>
</tr>
</tbody>
</table>

**Value Based System**

- Build around integration and cooperation of providers who manage a population
- Requires
  - Aligned incentives
  - Focus on quality
  - Regulatory environment makes participation very difficult
  - Reimbursement risk is high
- Shared savings
  - Quality metrics
  - Patient experience metrics
  - Cost metrics

**2013 Post Acute Impact**

- Payments bundled – saves 18 billion over 10 years
  - Medicare acute and post acute – pilot established by January 2013
  - Physician and inpatient reimbursement
  - Decreased payments assuming healthcare providers will become more efficient
  - Acute hosp responsible for the acute and post-acute stay for up to 30 days
  - Expand program by Jan. 2016
  - Expect other payers to follow with this strategy

**Value Based Purchasing Pay 4 Performance**

- Discharges October 1, 2013 or after
- Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, acute care, and hospice providers by requiring the Secretary of HHS
  - 17 clinical measures
  - 8 patient experience measures
- 1% of DRG reimbursement withheld
- Progresses to 2% by 2017
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2014

- Health Care Exchange – Sec 1311
  - States must establish by January 1, 2014
  - Rating system for qualified health plans through internet Website
  - Certify qualified health plans
- Under the new law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured American
- Insurance companies can no longer base premiums on your health care status

2015

- Reform fully implemented
- Effective January 1, 2015
  - A new provision will tie physician payments to the quality of care they provide.
  - Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care.

Opportunities

- Physical Therapists
  - Larger population served
  - Essential care that helps individuals return to function
  - Front line providers in preventative care
  - Manage chronic illness and increase physical activity
  - Adapt to disability
  - Regain and maintain functional independence
Uninsured

- Uninsured have risen to 50.7 million persons in 2010

Demographics

- Between 2010 and 2015, the 65 years of age and older population will grow 3 times faster than the population as whole

<table>
<thead>
<tr>
<th>National Resident Population</th>
<th>2010</th>
<th>2015</th>
<th>Estimated Five Year Growth</th>
<th>Percent Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>75,217</td>
<td>78,106</td>
<td>2,889</td>
<td>4%</td>
</tr>
<tr>
<td>18 to 64</td>
<td>113,808</td>
<td>116,686</td>
<td>2,878</td>
<td>3%</td>
</tr>
<tr>
<td>65 to 84</td>
<td>80,980</td>
<td>83,911</td>
<td>2,931</td>
<td>4%</td>
</tr>
<tr>
<td>65 and over</td>
<td>40,229</td>
<td>46,617</td>
<td>6,608</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td>310,234</td>
<td>325,540</td>
<td>15,306</td>
<td>5%</td>
</tr>
</tbody>
</table>

Expanded Coverage to 32 Million Additional Americans

- Effective January 1, 2014
- Americans who earn less than 133 percent of the poverty level (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years

Chronic Conditions

- Over 60 percent of all health care dollars are spent on chronic care conditions
- For the 65 years and older population, more than 76 percent have greater than one chronic conditions
- 50% of Medicare beneficiaries have five or more chronic conditions
- Regardless of age – the annual costs for a person with three or more chronic conditions is 3 to 5 times greater annually that those who have no chronic conditions
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What Does it Mean for Physical Therapy?

Change presents both opportunity and challenge

As physical therapists, we will need to:
- Demonstrate quality
- Identify new channels
- Be open to non-traditional models
  - PASS (Journal of PT, Nov, 2010)

Triple Aim

Each type of therapy service will need to develop strategies consistent with the Triple Aim

Move from:
- Outcomes
- Patient experience
- Affordability

To:
- Patient experience
- Affordability
Begin your plan:

“The first step towards getting somewhere is to decide that you are not going to stay where you are.” Anonymous

<table>
<thead>
<tr>
<th>Area of service</th>
<th>Patient Experience</th>
<th>Outcomes</th>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do you provide service?</td>
<td>What, how</td>
<td>Tools/measures</td>
<td>What can I/we control?</td>
</tr>
<tr>
<td>Know your rules/regs</td>
<td>Educate your team</td>
<td>Disciplined, deliberate work</td>
<td>May require new models</td>
</tr>
</tbody>
</table>

**Outcomes**
- Difficult area to measure for therapies
- Choose an element of quality
  - Sept, 2011 Journal of Acute Care Therapy
- Timeliness

**Affordability**
- Role of therapies in discharge planning and readmission
- Difficult discussions and decisions

**Acute Care**

*50+ health care providers provide services in a 5 day hospital stay*
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October 6, 2011

**Acute IP Rehab**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Patient Experience</th>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Well established FIM change</td>
<td>- Must have tool in place to measure</td>
<td>- Multiple studies demonstrate overall cost savings of acute rehab vs. NH for certain populations</td>
</tr>
<tr>
<td>- DC to community New:</td>
<td>- Historically is a hospital leader</td>
<td>- Lower readmissions</td>
</tr>
<tr>
<td>- UTI</td>
<td>- Cross functional team to address performance</td>
<td>- More durable outcomes</td>
</tr>
<tr>
<td>- Pressure sores</td>
<td>- Regular reporting</td>
<td>- Explore new models</td>
</tr>
<tr>
<td>- Any cause readmissions</td>
<td>- Exempt from HCAPS</td>
<td></td>
</tr>
</tbody>
</table>

**OP Rehab**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Patient Experience</th>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Challenge: no nationally benchmarked measures</td>
<td>- Must have robust tool in place</td>
<td>- Be open to new models</td>
</tr>
<tr>
<td>- Computer adapted patient self reports</td>
<td>- Vehicle to report both internally and externally</td>
<td>- Track patient across care experience</td>
</tr>
<tr>
<td>- Validated outcomes measures</td>
<td>- Customers are seeking this information</td>
<td>- Impact of therapies on total cost of care</td>
</tr>
<tr>
<td>- Choose something and begin collecting data</td>
<td>- Measureable, durable, meaningful</td>
<td>- Engage payer customers</td>
</tr>
</tbody>
</table>

**Home Health**

- **Patient Experience**
  - HHCAHPS survey
  - Links to quality reporting in 2012

- **Outcomes**
  - OASSIS
  - Home Health Compare
  - Public Reporting

- **Total Cost**
  - Post acute bundling
  - Affordable Care Act reduced reimbursement will not need to drive efficiency, care integration

**Occupational Health**

Several published reports have shown a positive impact from employee health and wellness programs:

- $3 - $6 ROI for every $1 invested over a two-to-five-year period (Am J Prev Med 2005)
- $5.93 ROI for every $1 invested (J Health Promot 2005)
- $3.93 ROI for every $1 invested (J Health Promot 2005)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Patient Experience</th>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Have robust metrics:</td>
<td>- Involve patient, employer in decision making</td>
<td>- Opportunity to drive wellness &amp; prevention to ultimately reduce cost</td>
</tr>
<tr>
<td>- RTW</td>
<td>- Develop tools that meet needs of all stakeholders</td>
<td>- Offer a mix of services</td>
</tr>
<tr>
<td>- Frequency, duration and intensity of injuries or illness</td>
<td>- Partnerships</td>
<td>Fee schedule and non fee schedule</td>
</tr>
</tbody>
</table>
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Research

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Patient Experience</th>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Need is to balance clinical care</td>
<td>- Research can help drive patient experience</td>
<td>- Apply clinical research methods to operational models</td>
</tr>
<tr>
<td>- Advance ability to track outcomes</td>
<td>- Practices must be patient-centric</td>
<td>- Collaborate</td>
</tr>
<tr>
<td>- Projects that are consistent with market needs</td>
<td>- Include &quot;voice of the patient&quot;</td>
<td>- Start somewhere</td>
</tr>
</tbody>
</table>

Long Term Care

(CNUs, LT&Cs, swing beds in CAHs)

CMS cuts will reduce Medicare payments to skilled nursing facilities by $79 billion over 10 years

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Patient Experience</th>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- MDS in place today</td>
<td>- No standard tool in place</td>
<td>- Final Rule in effect Oct. 1, 2011</td>
</tr>
<tr>
<td>- 8 Chronic care quality measures</td>
<td>- Most facilities have tool for patient, family reporting</td>
<td>- Cuts tied to recalculation of CMI</td>
</tr>
<tr>
<td>- NQF recommends 4 chronic care measures and 3 post acute measures</td>
<td></td>
<td>- Therapies will be forced to examine current models of group and co treatments</td>
</tr>
<tr>
<td>- Therapies need to be integrated into facility plans</td>
<td></td>
<td>- Post acute bundling will force more care integration</td>
</tr>
</tbody>
</table>

Resources

- American Hospital Association News
- Minnesota Hospital Association
- American Physical Therapy Association on Health Care reform
- http://www.aapa.org/AM/Template.cfm?Section=Current_Legislatio n&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=64987#plans
- Health Care ‘Accountability Moment’ Chas Roades The Advisory Board 2010
- http://thomas.loc.gov/cgi-bin/D?c111:7:temp/~c1114kFqZ
- Bureau of Economic Analysis
- Minnesota Consortium for Individuals with Disability
- Kaiser Family Foundation
- http://www.kff.org and
- US Department of Health and Human Services
- Amerinet
- Health Care Reform, Where Do We Stand
- 2011 Executive Briefing

A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.

- Winston Churchill