ASHA / American Speech-Language-Hearing Association

Health Reform in 2017 and Beyond: Staying Afloat in a Sea of Change

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ASHA /Disclosure

Daneen Grooms, MHSA, Director of Health Reform Analysis and Advocacy

Financial: Paid employee of ASHA

Non-Financial: Contributor of for-sale ASHA products on the topic of health plan payments, coding, and payer advocacy. Receives no compensation for product sales.

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ASHA / Agenda

- Affordable Care Act (ACA) and Essential Health Benefits (EHBs)
  - *Coverage gains made to date*
- Habilitation Coverage under the New Administration
  - *Opportunities, Challenges, Threats*
- What's Happening in Oregon?
  - *State-Based Advocacy: What You Can Do*
- The ACA and Value-Based Care
  - *Moving from Fee-for-Service to Value*
- The ACA and Nondiscrimination in Delivery of Healthcare
  - *Providing Language Assistance to Patients*

ASHA / Affordable Care Act and EHBs

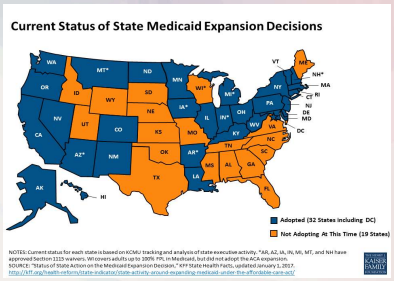
ASHA / What are the EHB categories required by the ACA?

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization
4. Maternity and Newborn Care
5. Mental Health and Substance Use Disorder Services
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

ASHA / Rehabilitative and Habilitative Services and Devices

- Individual and small group (50 or fewer employees) health plans operating inside and outside of the Marketplace have to cover these services
- **Does not apply** to Medicare, traditional Medicaid or private insurance plans that are self-funded and/or large group health plans (more than 50 employees)
- States expanding their Medicaid programs must provide EHBs
  - **Oregon has expanded the Oregon Health Plan**

ASHA / EHBs: Snapshot of Medicaid Expansion by State



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/

ASHA /

Rehabilitative and Habilitative Services and Devices Benefit

ASHA / Uniform Definition and Separate Visit Limits

- Habilitation services and devices:
  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.
- Audiology services and devices are included

ASHA / Definition for Rehabilitation Services and Devices

- Healthcare 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 and speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings
- Devices for rehabilitation are covered and must be included
- ASHA supports the inclusion of audiology as an example of other covered services

ASHA / Separate Visit Limits

- Visit limits for habilitative services cannot be combined with and must be separate and distinct from the rehabilitative services benefit
- ACA compliant health plans may not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of habilitative services
  - HCPCS modifier SZ designates Habilitation Services on claim forms

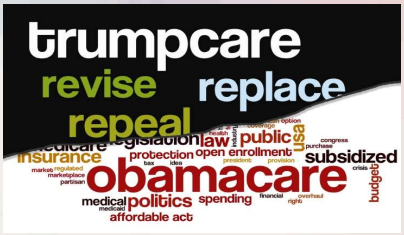
New in 2018:

- **Modifier 96 (Habilitative services)**
- **Modifier 97 (Rehabilitative services)**

ASHA /

Habilitation Coverage under the Trump Administration

ASHA / New Administration, New Rules?



ASHA / Congressional Action

Efforts to partially repeal the ACA :

- American Health Care Act
- Better Care Reconciliation Act
- Obamacare Repeal Reconciliation Act
- Health Care Freedom Act
- Graham-Cassidy-Heller-Johnson Amendment

Efforts to stabilize the ACA insurance market:

- The Senate Health Education Labor and Pension committee held briefings and are crafting a bipartisan bill

ASHA / Regulatory Action

Potential efforts to dismantle the ACA:

- Rescind both the federal definition for habilitation and the separate visit limit requirement for habilitation and rehabilitation
- Reduce funding for Open Enrollment outreach and education
- Return oversight of ACA health plan functions to states
  - Network adequacy
- Flexibility in Section 1332 waivers that allow states to deviate from the ACA

ASHA / Executive Action

Actions taken to dismantle the ACA:

- Leave uncertainty regarding cost-sharing subsidy payments to ACA insurers
- Allow small business and other groups to buy insurance together via Association Health Plans (AHP)
- Direct the federal government to lift limits on short-term insurance plans (STIP)
  - President Trump issued an Executive Order instructing federal agencies to review/issue regulations that would expand access to AHPs and STIPs

ASHA / What's Happening In Oregon?

ASHA / Health Insurance Marketplace

www.healthcare.gov/

State-Based Exchange on the Federal Platform

ASHA / Health Plan Changes for 2018

- Five ACA plans will offer coverage:
  - BridgeSpan
  - Kaiser Permanente
  - Moda
  - Pacific Source
  - Providence Health Plan: will be the only health plan for Lane, Lincoln and Tillamook counties

ASHA / Oregon Enacted Legislation to Preserve ACA Gains

- HB 2391: Establishes Oregon Reinsurance Program to stabilize rates and premiums for individual health benefit plans and provide greater financial certainty to health insurance consumers.
- HB 2342: Grants emergency powers to the Insurance department to enact market stabilization rules if federal law changes that threaten the life or health of Oregonians.
  - Essential health benefits are considered a consumer protection that will be saved by this order.

ASHA /

Oregon's Benchmark Plan

ASHA / What Is a Benchmark Plan?

- A benchmark plan serves as the benefit standard for health plans required to offer EHB in the state.

ASHA / Oregon's Benchmark Plan

Benchmark Plan: PacificSource Health Plans Preferred Codeduct Value	
✓ Inpatient and outpatient rehabilitation for speech therapy	✓ 30 days/condition; 60 days if head or spinal cord injury (Inpatient) ✓ 30 visits/year; up to 30 additional visits if neurological condition ✓ Coverage for cognitive therapy
✓ Habilitation Services	✓ Covered in accordance with the federal uniform definition ✓ Same as above for visit limits
◆ Cochlear implants and SGDs	◆ Unclear; not specifically mentioned
✓ Hearing aids	✓ Covered (no age limits)
◆ Audiology	◆ Listed as a covered professional for hearing tests

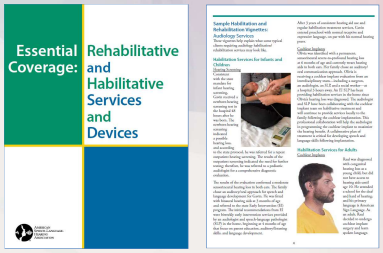
ASHA /

State-Based Advocacy: What You Can Do?

ASHA / Oregon Habilitation Advocate

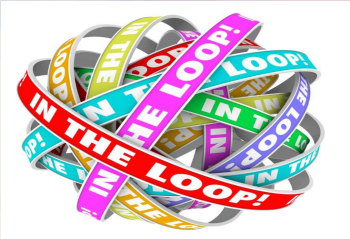
- At present, Oregon has not identified a habilitation advocacy point person

ASHA / Habilitation Advocacy Guide



http://www.asha.org/uploadedFiles/Rehabilitative-Habilitative-Services-Devices.pdf

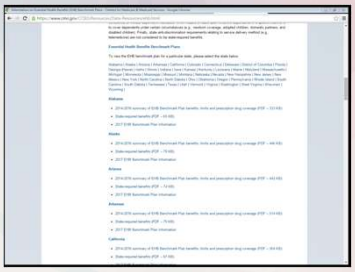
ASHA / Monitor and Track Your State-Required Benefits



ASHA / Step 1: Track State-Required Benefits

- At the **federal level**
  - Visit CCIIO's webpage and scroll down to find your state https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html
  - Click on your state and select "state-required benefits"
  - Review the document, paying particular attention to individual and small group market coverage
  - Look for: habilitative services; hearing aids; rehabilitative speech therapy; cleft lip/palate; autism spectrum disorder; cochlear implants; speech, language or hearing disorder

ASHA / CCIIO Webpage for State-Required Benefits



ASHA / Step 2: Monitor and Track State-Required Benefits

- At the **state level**, if state-required benefits do not meet individuals' needs:
  - Reach out to the appropriate contact in the Department of Insurance to request a meeting to share specific concerns
  - Reach out to state legislators to make them aware
  - Speak to your colleagues at the clinic, hospital, or practice setting
  - Collaborate with other like-minded state associations and groups (i.e., patient advocacy groups)

ASHA / State-Required Benefits in the Individual Market

Mandates exist for:

- Habilitative services
- Hearing aids
- Prosthetic devices

ASHA /

Step-by-Step Advocacy

ASHA / Step 1: Inform

- Communicate with your:
  - membership
  - lobbyists
  - grassroots organizations
- Provide talking points to ensure everyone is on the same page

ASHA /Talking Points

- Explain that if the EHB requirement is modified via federal regulations and/or guidance, states will most likely have to determine the benefits health plans must cover
- Coverage for rehabilitative services and devices is likely to remain because employer-sponsored health plans generally offer these benefits
- Prior to the ACA, few Americans understood what habiliation is, let alone the benefit it brings to those who rely on these services and devices
- Individuals who need habiliation services and devices rely on their health care coverage to acquire, learn or improve skills and functioning for daily living

ASHA / Talking Points

- Habilitative services and devices are typically appropriate for individuals with many types of neurological and developmental conditions that—in the absence of such services—prevent them from acquiring skills and functions over the course of their lives.
- In recent years the value of habilitative services has been widely acknowledged.
  - The National Association of Insurance Commissioners acknowledged that habilitative services are medically necessary
- The continued coverage of the rehabilitation and habilitation benefit is critical to ensuring citizens have access to these services

ASHA /Step 2: Identify Issues

- Analyze the insurance mandates for speech therapy and audiology services
- Monitor and track how rehabilitative and habilitative services and devices are covered
- Establish whether coverage is adequate for patients' needs

ASHA / Step 3: Develop an Advocacy Plan

- Identify key areas where advocacy is needed
- Identify gaps in coverage and include state-specific recommendations in your comments to decision makers

ASHA / Advocacy In Oregon: Who to Contact?

Oregon Legislature

- consists of a 60-member House of Representatives and 30-member Senate
- The Legislature is currently adjourned
- Visit www.oregonlegislature.gov to find your legislator and for information on current happenings in the State

Oregon Insurance Department

- Division of Financial Regulation oversees health insurance
- Website for information: http://www.oregon.gov/dcbs/Pages/index.aspx
- Richard Blackwell, Senior Policy Manager
  - Richard.Y.Blackwell@Oregon.gov
  - Office: 503-947-7056

ASHA /

The ACA and Value-Based Care

Moving from Fee-for-Service to Value

ASHA / Healthcare Delivery and Payment Is Transforming

Quantity → Quality

- Fee-for-service = payment for *quantity* of care
- Value-based = payment for *quality* of care
- The trend is **moving toward value-based**
  (As a result of the Affordable Care Act in 2010)

Value: Improved quality at reduced cost

ASHA / Why This Matters

- Private payers, Medicare and Medicaid are moving in this direction
  - Goal: to slow rising healthcare costs
- Value-based is the future
  All payers are moving toward a value-based system that focuses on quality and cost

Take accountability for increasing the quality and lowering the costs of the care you provide

ASHA /

Description of Alternative Payment Models

ASHA / Alternative Payment Models (APMs)

- Accountable care organizations
- Episode of care
- Bundled payment
- Patient-centered medical home

ASHA / Accountable Care Organizations (ACOs)

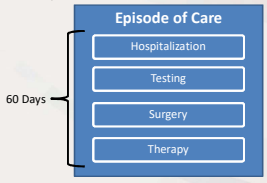
ACOs

- Assume accountability for the cost and quality of care for a **defined population of patients**
- Coordinate the services of its providers in various healthcare settings to manage patients' needs
- Health information technology is integral
- Can be hospital-driven or hospital/provider arrangements
- Medicare and private sector ACOs exist
  http://www.beckershospitalreview.com/lists/100-accountable-care-organizations-to-know-2015.html

ASHA / Episode of Care

Encompasses all services provided to a patient with an **identified condition** within a **specific period of time** across a continuum of care in an integrated healthcare system (e.g., Stroke)

Example: Stroke



- ❑ Did services improve outcome?
- ❑ Was spending reduced?
- ❑ Was treatment completed within the required timeframe?

ASHA / Bundled Payment

- Represents a single fixed payment for an identified condition
- Better coordination of care for patients
- Works really well for procedures/services with a **discrete stop/end time**
- Can also be implemented for **chronic conditions**

ASHA / Patient-Centered Medical Home (PCMH)

- A model, not a "home"
- The PCP coordinates care with other providers ("gatekeeper")
- Enhanced care coordination and communication, particularly useful for chronic conditions
- Intended to minimize fragmentation of information between providers
- Can be integrated into ACOs

ASHA / Medicare and APMs

Demonstration Projects under CMS's Innovation Center

ASHA / Bundled Payment for Care Improvement Initiative (BPCI)

What is it?

- An incentive program

What is the goal?

- To reduce the cost of a 90-day episode of care (against a target cost)
- To meet the healthcare needs of the beneficiary
- To improve the beneficiary's experience of care
- To deliver efficient, high-quality care

How does it work?

- Acute and post-acute providers coordinate services for the Medicare beneficiary
- If successful, providers share in the savings in a method known as "gain sharing"
- Encourages providers to work together for better patient outcomes at reduced costs

ASHA /BPCI

Retrospective Costs evaluated *after* treatment

Prospective Costs prescribed *before* treatment

Model #	Retrospective Acute	Retrospective Post-Acute	Prospective Acute	Hospital Stay Only
1	Yes	-	-	Yes
2	Yes	Yes	-	-
3	-	Yes	-	-
4	-	-	Yes	Yes

- Payment arrangements include financial and performance accountability of participating organizations
- Diabetes, stroke, UTI, syncope, and collapse are examples of episodes of care

ASHA / Comprehensive Care for Joint Replacement Model (CJR)

- Holds hospitals accountable for all the costs of hip and knee replacements for 90 days
  - Five-year demonstration project as of April 2016
  - Operating in select Metropolitan Statistical Areas (MSAs)
    - Portland-Vancouver-Hillsboro, OR-WA currently included
- Represents a single fixed payment (target price) to hospitals
- Episode of care
  - Begins when an eligible Medicare beneficiary is admitted to an acute-care hospital
  - Triggered by diagnosis (MS-DRG 469 and MS-DRG 470)
  - Ends 90 days after discharge from the hospital
  - All related care covered under Medicare Parts A and B during the 90 days are included in the bundle

ASHA / Comprehensive Care for Joint Replacement Model (CJR)

- SLP services
  - Communication
  - Cognition
  - Swallowing-related diagnoses

  Because they are either ***due to chronic conditions whose care may be affected by the procedure, or to complications of the procedure such as a stroke***
- Audiology services
  - Included if provided within the 90-day window

ASHA / Accountable Care Organizations (ACOs)

- Medicare Shared Savings Program (MSSP)
  - Permanent program established by the ACA
  - Network of doctors, hospitals and other providers who work together to lower their health care costs while meeting quality measurement standards for assigned Medicare beneficiaries
  - There are 3 tracks: Track 1 (one-sided risk); Tracks 2 and 3 (two-sided risk)
- Pioneer Model
  - Designed for organizations and providers already experienced in coordinating patient care across settings
  - Allow providers to move more rapidly from a shared saving payment model to a population-based payment model
  - Designed to work in coordination with private payers by aligning provider incentives

ASHA / ACOs

- Next Generation Model
  - Builds upon Pioneer ACO and MSSP
  - Designed for ACOs experienced in coordinating patient care
  - Providers assume higher levels of financial risk and reward than available under Pioneer Model and MSSP
  - Allows ACOs to move from fee-for-service to population based payments
  - Includes “benefit enhancement” tools (e.g. greater access to home visits, allow beneficiary to confirm relationship with ACO) to help improve beneficiary engagement

ASHA /APMs under MACRA

ASHA /Medicare Access and CHIP Reauthorization ACT (MACRA)

- Transitions Medicare outpatient payment to payment based on quality, outcomes, and efficiency
- Repeals sustainable growth rate (SGR)
- Participation in an APM is one way to meet the requirements

ASHA /Examples of Qualifying APMs

- CJR Payment Model Track 1
- CMS Medicare Shared Savings Program ACO Tracks 2 and 3
- Next Generation ACO
- Comprehensive Primary Care Plus
- Comprehensive ESRD Care- Two-Sided Risk
- Oncology Care Model- Two-Sided Risk

Why Should Providers Participate in an Advanced APM?

Audiologists and SLPs who are qualified Advanced APM participants will receive a **5% bonus payment** for covered Part B Medicare payments

Advanced APM Requirements

The clinician:

- Participates in an APM that requires use of certified EHR technology
- Uses quality measures comparable to the Merit-Based Incentive Payment System (MIPS)
- Either bears financial risk for monetary losses in excess of a nominal amount or is a PCMH under section 1115A

Oregon State Initiatives

Oregon Patient-Centered Primary Care Home Program (PCPCH)

- Established in 2009 by legislature and adopted by Oregon Medicaid
- PCPCH recognizes primary care practices that seek PCMH status
- The goal is that 75% of Oregonians will have access to care in a PCPCH that will offer:
  - Better care coordination that is patient-centered
  - After-hours access

ASHA / Oregon Coordinated Care Organizations (CCOs)

- Statewide Medicaid ACO launched in 2012 that incorporates PCPCH practices
- 15 CCOs operate across the state that receive a budget to create APM payment methodologies for providers
  - https://www.ccooregon.org/resources/ccos/
- CCOs provide care to more than 600,000 Medicaid patients

ASHA / Comprehensive Primary Care Plus (CPC+)

- CPC+ is a 5 year primary care medical home initiative where public and private payers align with Medicare's program model to improve quality, access and efficiency of primary care
  - https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
- Oregon Medicaid is participating
- Practices are expected to demonstrate progress on:
  - Access and Continuity
  - Care Management
  - Patient and Caregiver Engagement
  - Comprehensiveness and Coordination

ASHA / Considerations and Next Steps

ASHA / Ways to Start Thinking About Value

- Recognize that using services creates expense rather than revenue in APMs
- Invest in technology and other resources (e.g., CEHRT) that help make your practice more efficient and improve the quality of patient care
- Make care delivery a team effort — everyone has an important role to play
- Seek out evidence-based resources and provide evidence-based services to all patients
- Learn about new payment delivery models in your area

ASHA / What You Need to Know About Value-Based Arrangements

- Get ahead of the curve and gain experience. Medicare, Medicaid and private payers are moving to a value-based reimbursement system
- Evaluate the benefits and risks of your participation based on an assessment of your practice and market size
- Value-based contracts pay providers based not only on services provided, but on the quality of care and the appropriate utilization of services
- Specific quality measures will be used to evaluate your performance
  - ASHA is developing a Qualified Clinical Data Registry (NOMS for audiology and SLP)

ASHA / Advantages of Entering Into a Value-Based Arrangement

- Open lines of communications with other providers (e.g., hospitals, PACs) and payers. Think of the provider (e.g., PAC or hospital) or payer as a partner collaborating on ways to get better care to patients
  - Choose a provider and/or payer with whom you have an established, positive relationship
- Learn about opportunities to improve the care you provide. Choose a topic with which you are comfortable and interested
- Private practices may qualify to receive a 5% incentive payment under Medicare's advanced APM models
- Attract referrals from physicians, PACs, and other providers by delivering the best care at a competitive cost

ASHA /

The ACA and Nondiscrimination in Delivery of Healthcare

ASHA / **Protections for Individuals with Limited English Proficiency (LEP)**

- Consistent with longstanding principles, providers are required to take reasonable steps to offer oral or written language assistance to LEP individuals
- An LEP individual is a person whose primary language for communication is not English and who has limited ability to read, write, speak or understand English
- An LEP individual cannot be expected to provide his/her own interpreter

ASHA / **Protections for Individuals with Disabilities**

- Consistent with existing requirements, the ACA requires providers to take appropriate steps to ensure communications with individuals with disabilities are as effective as communication with others
- Providers are required to offer auxiliary aids and services such as American Sign Language interpreters to give people with disabilities an equal opportunity to benefit from services
- Providers are required to post a notice of individuals' rights providing information about communication assistance, among other information
  - Office for Civil Rights: https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
  - ASHA: http://leader.pubs.asha.org/article.aspx?articleid=2541720

ASHA / Questions?

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