Health Care Reform Implementation and Occupational Therapy

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Note to readers: This column debuts a new series on health policy and its effects on occupational therapy. The American Occupational Therapy Association’s (AOTA’s) objective is to ensure that the Centennial Vision’s goal of occupational therapy as “powerful, widely recognized, science-based, and evidence-driven profession” is brought to fruition as health care reform and related changes are implemented. Opportunities may exist to expand occupational therapy practice and recognition, but challenges may arise from extensive cost cutting, reductions in workforce, or changes in provider qualifications. We encourage questions and feedback as well as seek authors and ideas for future topics. E-mail hcr@aota.org.

The roots of modern health insurance can be traced to 1929, when Baylor Hospital in Dallas, Texas, began a prepaid health program with a local teaching union to begin what is thought to be the first example of modern health insurance (Goodridge & Arquiquist, 2011). Since that time, many attempts have been made to overhaul the U.S. system of health care delivery and payment for services—and almost as many failures have occurred. In the past few decades there has been wide criticism over waste, fraud, and abuse; lack of adequate health insurance coverage for millions of Americans; and poorly coordinated care delivered in a fragmented system. Cost, quality, and access to care continue to be major issues that drive the debate on how health care should be delivered and paid for. In addition, increased attention is being given to support preventative health care measures.

Occupational therapy also has grown and changed since its beginnings in 1917 and now has the potential to become an even more important part of the health care system as reform moves forward.

Patient Protection and Affordable Health Care Act

Despite widespread disagreement and ardent opposition, on March 23, 2010, President Barak Obama had garnered sufficient Congressional support to pass and then sign the Patient Protection and Affordable Health Care Act (PPACA) into law. The law is intended to expand health care 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.

The PPACA has been estimated to cost $848 billion over a 10-yr period but would be fully offset by new taxes and revenues, some of which are related to cost-cutting and changes in Medicare and Medicaid. One report indicated that because of overall savings in health care, the law would actually reduce the country’s deficit by $131 billion over the same time (OpenCongress.org, 2011).

Between now and 2014, implementation details will be worked out at the federal and state levels, but in general the law is intended to accomplish the following changes in the U.S. health care system:

- Individual mandate for health insurance. Most individuals in the United States will be required to have health insurance...
beginning in 2014. 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. Exceptions will be given for financial hardship and religious objections, for certain Native Americans, for people who have been uninsured for fewer than 3 months, for those for whom the lowest cost health plan exceeds 8% of income, and for individuals with an income below the tax-filing threshold (Henry J. Kaiser Family Foundation, 2010).

- **Health insurance exchanges.** 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. Premium and cost-sharing credits will be available to families with incomes up to 400% of the Federal Poverty Level to make coverage more affordable (Henry J. Kaiser Family Foundation, 2010). Small businesses could purchase coverage through a separate exchange. This new type of health insurance marketplace will provide consumers with information to enable them to choose among plans that are designed along the lines of federal and state requirements.

- **New mandates for employers.** Employers will be required to pay penalties for employees who receive tax credits for health insurance through the exchange, with exceptions for small employers (those with at least 2 but no more than 50 employees on average).

- **Changes to insurance regulation.** New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums on the basis of health status and gender. Lifetime limits on coverage will be eliminated, and young adults will be able to remain on their parent’s health insurance until age 26.

- **Medicaid expansion.** 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.

Specific features of health care reform implementation include the following proposed structures that are to be tested in Medicare first for changing delivery and payment of care:

- **Postacute care bundling** uses a single payment for all services related to a specific treatment or condition (e.g., a stroke), possibly spanning multiple providers in multiple settings (RAND Corporation, 2011). A single episode of care might include initial hospitalization; rehospitalization; postacute care; and physician and other services, such as occupational therapy.

- **Accountable care organizations (ACOs)** are groups of providers associated with a defined population of patients that are accountable for the quality and cost of care delivered to that population. Providers could include a hospital, a group of primary care providers, specialists and, possibly, other health professionals who share responsibility for the quality and cost of care provided to patients as care is provided across multiple settings (e.g., acute care hospital, skilled nursing facility, patient home).

- **Medical home models** focus on coordination of care and are led by a personal physician with the patient serving as the focal point of all medical activity. The medical home model promotes a team-based approach to care of a patient through a spectrum of disease states and across the various stages of life.

### Implications for Occupational Therapy

It seems likely that the PPACA presents both opportunities for and threats to the occupational therapy profession.

#### Opportunities

Opportunities for promoting and expanding the role of occupational therapy within the health care system might include:

- Recognition as an integral member of the primary care team within reform strategies such as medical homes and ACOs. To do this, occupational therapy practitioners must define our possible roles in primary care and articulate our contribution to meeting the health care needs of individuals as well as to achieving the positive outcomes these new structures will be working toward—cost effectiveness, quality care, and improved coordination.

- Increased involvement in prevention and wellness activities and interventions. The PPACA includes a mandate for an annual wellness visit for Medicare patients with their physician. The visit will include a personal risk assessment (including any mental health conditions) and a review of functional ability and level of safety, including an assessment of any cognitive impairment and screening for depression (Healthcare.gov, 2011). These visits could set the stage for increased recognition of occupational therapy as an intervention to address problems and issues identified as compromising health.

- Inclusion of “rehabilitation and habilitation services” as a required category in the mandatory benefits package. Occupational therapy has always been involved in providing habilitative services, but mostly through special programs like the Individuals With Disabilities Education Improvement Act of 2004 (IDEA) Part C Early Intervention Program. With expanded coverage in basic insurance, the potential for increased provision of habilitation may create opportunities for practitioners in community settings; with children and adolescents; and in the areas of self-management, participation, and full function.

- Inclusion of mental health and substance abuse disorder services, including “behavioral health treatment,” as a required category in the mandatory essential benefits package. This inclusion may create opportunities for occupational therapy practitioners to provide these services, because more Americans will have access to health insurance. Occupational therapy must become part of both mental health and physical health systems to ensure integration.

Coordination of services may be improved through the creation of medical
homes, ACOs, and the promotion of cost-effective care management. Occupational therapy can be an essential part of these systems to provide interventions and expertise on self-management for clients, especially those with chronic conditions.

**Challenges**

Possible threats to the profession as a result of implementation of PPACA might include:

- Decreased direct reimbursement for services if new payment structures focus on paying for episodes of care or if the new structures focus on revenues and are not held accountable for quality and positive patient outcomes;
- Exclusion from the development of key implementation strategies such as medical homes if the profession is not proactive in defining potential and actual roles and the contributions that occupational therapy can make to objectives such as cost-effectiveness, full recovery, full return to productivity, and other societal aspects of health care; and
- Other disciplines establishing themselves as key players in rehabilitation, habilitation, mental health, prevention and wellness, chronic illness management, and long-term care. Our advocacy—in policy and in our daily work—must defend occupational therapy’s capabilities as we collaborate with others.

Although occupational therapy has a solid body of knowledge and research, momentum must continue in this area, and we must ask and answer the questions that are most important to the new system: What are the costs? How is occupational therapy effective? What is the quality of care? What are the qualifications of providers?

**AOTA’s Response to PPACA’s Implementation**

AOTA has adopted a broad response to health care reform implementation that includes active lobbying and advocacy at the federal and state levels by staff in AOTA’s Federal Affairs and State Affairs groups. AOTA has responded to numerous requests of federal agencies for comments on some aspects of change. For instance, in a request for comment on the U.S. Department of Health and Human Services’ Health Care Quality Initiative, AOTA emphasized elements such as including “quality of life” as a measurement rather than simply disease status. In response to request for ideas about how best to establish ACOs in Medicare, AOTA encouraged the Centers for Medicare and Medicaid Services to greatly expand the quality measures for which ACOs would be accountable to include things such as the prevention of falls in the home. AOTA also has promoted a focus on self-management as a means of healthy lifestyle redesign, prevention, disease management, and limiting the impact of chronic disease (see AOTA’s comments on legislation at “Health Care Reform Spotlight” at www.aota.org/Practitioners/Advocacy/Federal/Reform.aspx).

AOTA also has been working to enable state affiliates to respond to the many issues that will be determined at the state government level, providing training and resources to promote this critical advocacy. Moreover, AOTA is actively providing continued support and resources to guide individual members in advocacy at all levels of government, with private payers and with other providers. Resources are provided at workshops at the AOTA Annual Conference & Expo, in Town Hall forums, and on the AOTA Web site at www.aota.org. AOTA also promotes and supports the development, evaluation, and dissemination of evidence that supports occupational therapy in key areas related to health care reform, such as prevention, wellness, chronic disease management, and cost-reduction strategies, which improve quality of life.

**Getting Involved**

The Centennial Vision (AOTA, 2007) creates a brilliant light for the occupational therapy profession to move toward. Health care reform is creating many opportunities in which occupational therapy can move ahead to the Centennial Vision’s goals for the profession of power, wide recognition, inclusion of science and evidence in practice, and ability to meet the occupational needs of society. But these aspirations will not happen automatically.

Efforts have been implemented in the AOTA volunteer sector through the establishment of an Ad Hoc Committee on Health Care Reform Implementation appointed by President Florence Clark in 2010. The committee includes volunteers who are coordinating the efforts of working groups on several focused areas of health care reform:

- Health benefits/medical necessity
- ACOs/medical homes
- Chronic care/self-management
- Mental health
- Tele health
- Prevention and wellness
- Long-term care.

Their purpose is to analyze the issues and opportunities in health care reform, to educate the profession about these issues, and to strategize ways in which the profession can influence the implementation of health care reform. Working groups may be added or disbanded as we learn more about the specifics of PPACA implementation and its real impact on the profession.

Each working group comprises AOTA members with interest and expertise in their group’s focus area. Members include researchers in areas such as chronic illness and disease management, practitioners in clinical areas ranging from long-term care to mental health, and AOTA members with varied backgrounds interested in health advocacy and health care reform. The functions of the working groups include:

- Providing consultation and guidance to AOTA advocacy staff,
- Reviewing drafts of official AOTA comments to governmental and regulatory agencies or on AOTA Official Documents, and
- Developing educational materials and resources for AOTA members.

Many of the volunteers have been identified through the COOL system (Coordinated Online Opportunities for Leadership) on the AOTA Web site (see www.aota.org/Governance/Leadership.aspx). AOTA members interested in becoming involved in AOTA activities can register and express interest in a wide range of volunteer service and leadership opportunities.

Working together, we can take full advantage of the opportunity to fulfill the
Centennial Vision and the promise of the occupational therapy profession. We must each be watchful for chances to contribute and create our own energy as changes to health care become reality.

References


