Healthcare Reform in the States:
What You Need to Know –What We Need to Do

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Need Reform?

- **Health expenditures now 18% of GNP. . . growing to 20%**
- **Medicare and Medicaid now 21% of federal spending. . . growing to 25%**
- **Uninsured now 51 million. . . growing to 55+ million**
- **Both Market and Government Forces are Driving Reform**

How did we get here?

- Wage controls during WW II caused employers to look for "benefits" to lure workers
- The War Labor Board determined that "fringe benefits" such as sick leave and health insurance were not "wages"
- Tying health insurance to employment became the norm

How did we get here?

- Fee for Service system has incentivized providers to simply do more
- Lack of coordination has led to duplication, waste and suboptimal care
- Americans want everything
- Poor planning for the end of life

"You can always count on Americans to do the right thing, after they've tried everything else."

Winston Churchill

Patient Protection and Affordable Care Act

Public Law 111-148

Signed into law March 23, 2010

http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

AAPA's Principles for Health Care Reform

★Use of evidence-based medicine
★ Physician-directed teams
★ Optimal utilization of primary care
★ Health promotion and disease prevention
★ Quality, affordable cost-effective health care
★ Comparative-effectiveness information

What Was in the PPACA for PAs?

☑Order SNF under Medicare
☑ 10% Bonus for Primary Care Codes
☑ Increased Support through the National Health Service Corps
☑ Increased Funding for PA Education
☑ Loan Repayment for PA Faculty
☑ Full Integration of PAs in New Models of Care

Implemented in 2011

- PAs eligible for 10% primary care bonus payment (60% threshold for office, SNF, home visits)
- Able to order/certify post-hospital SNF (transfer from hospital to SNF; physician still must perform comprehensive visit)
- PAs may perform Welcome to Medicare Exams and the new annual wellness exams.

Implemented in 2011

PAs can deliver tele-health services including:

- kidney disease education
- diabetes self-management training
- medical nutritional therapy
- subsequent hospital services, and
- subsequent nursing facility care.

Implemented in 2011 – Home Health

- Requirement for a face-to-face exam for home health (90-days before or no later than 30-days after certification)
- PAs may perform the face-to-face exam; physician must still sign certification
- PAs may deliver Care Plan Oversight services after home health certification by a physician.

Implications for the PA Profession

★Recognition

★ Incentive and Momentum to Remove Federal and State Barriers to PA Practice

★Being specifically named in the statute is a springboard to continued inclusion

For Patients – Already Implemented

- ❖Coverage of Adult Children up to 26
- ❖Rx Coverage for Seniors
- ❖High Risk Pool for Individuals with Pre-Existing Conditions
- ❖Cost-free Preventive Services
- ❖Choice of Primary Care Provider, OB/GYN, pediatrician
- ❖Use of nearest ER without penalty

For Patients – Already Implemented

Insurers can no longer –

- ↓Deny Coverage to Children with Pre-Existing Conditions
- ↓ Impose Lifetime Benefits
- ↓ Cancel a Policy without Proving Fraud
- ↓ Deny Claims without Appeal

For Patients

- ❖Team-Based Primary Care
- ❖Disease Prevention & Health Promotion
- ❖Care Coordination

In 2014

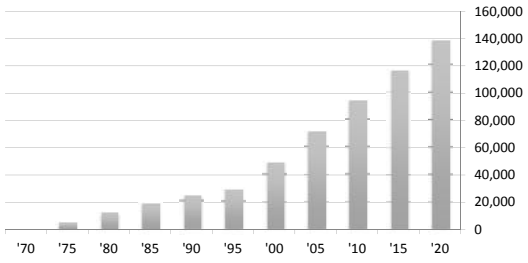
The plan is to be fully operational –

- ➔State Insurance Exchange Programs offering affordable health insurance coverage
- ➔ Tax penalty imposed on uninsured adults without coverage
- ➔ Fee imposed on large employers who do not offer health insurance coverage.

PAs are key to implementation, But Only If

- ➔Increase Support for PA Education to Grow the PA Workforce
- ➔ Eliminate Barriers to Care Existing in Federal Law and Regulations
- ➔Fully Integrate PAs in New Models of Care
- ➔State Laws Allow Full Utilization of PAs
- ➔Reimbursement Systems Cover PAs

Number of PA Graduates

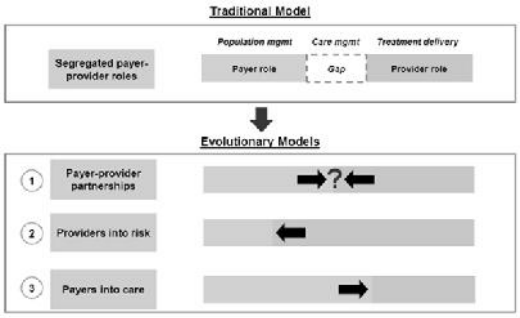


News Release

FOR IMMEDIATE RELEASE
Monday, March 12, 2012
Policies give States more flexibility to establish Affordable Insurance Exchanges

WASHINGTON, DC- Health and Human Services Secretary Kathleen Sebelius today announced policies to assist States in building Affordable Insurance Exchanges. Starting in 2014, these one-stop marketplaces will allow consumers and small businesses to choose a private health insurance plan and offer the public the same kinds of insurance choices as members of Congress.

New Competitive Structures



Accountable Care Organizations

- Local or regional organizations consisting of health care professionals, typically one or more hospitals and related health care entities that have a formal or informal relationship
- Jointly responsible (or accountable) for achieving measurable improvements in the quality and cost of health care delivered within a given community.

Accountable Care Organizations

- Health care professionals and organizations financial success will be based on patient care outcomes instead of number of services delivered
- ACOs will have a strong base of primary care professionals, but may also provide a wide range of specialty & ancillary care services.

Accountable Care Organizations

- Expectation is that ACO participants will share information and better coordinate patient care activities
- PAs must work to assure that ACOs use appropriate interdisciplinary models, that recognize the efficiencies of the team approach
- For the first time, many health care professionals will have to understand and deal with the managing financial risk.

ACO – Goals for PAs

- Inclusion as eligible professionals in similar fashion to physicians/NPs
- Immunity from traditional anti-trust rules/provisions to allow for flexible relationships and the sharing of financial and other data
- Inclusion in the implementation phases
- Concern over how certified RHCs and FQHCs will be integrated into the federal ACO model.

CMS Pioneer ACOs

Market ACOs

From 40 ER visits to zero in one year: coordinated care makes the difference for asthma

A few years ago St. Clair Davis was going to the emergency room almost every ten days for treatment of his asthma. "I didn't like that I had to go there," Davis says. "But I couldn't breathe, and I'd get scared, so I'd call 911."

Coordinated primary care at Central City Concern has completely turned St. Clair's life around.

Insurance Exchanges

- Goal is to establish insurance plan options for uninsured individuals
- Provide a competitive (cost-effective), simplified array of insurance plans for purchase for those who lack health insurance.

Insurance Exchanges

- Fully operational by 2014
- Federal government is granting up to $1 million in seed money to each state to start/implement insurance exchanges.

Insurance Exchanges – What Will Be Covered?

- US Department of Health & Human Services (HHS) has defined an "essential benefit package"

Much of the decision making will take place at the state level

Medical Home

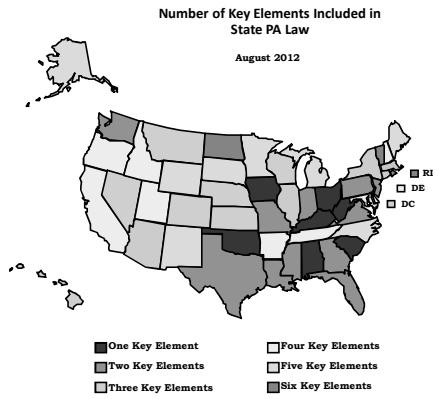
- Numerous definitions as to who is included
- National Committee on Quality Assurance changed their list to include PAs
- Patient-centered Primary Care Collaborative definition does not officially include PAs and NPs.

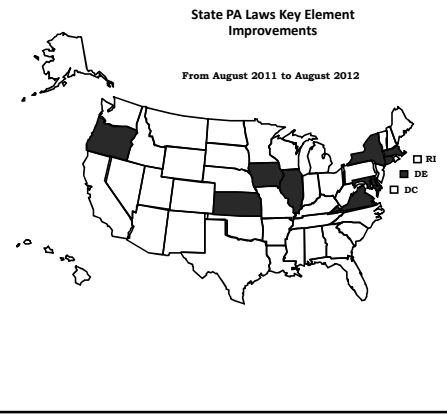
Medical Home

- Some private insurance companies are beginning medical home projects on their own
- Concerns over their concept of who may lead a medical home (BCBS Maryland)
- Concepts of supervision/collaboration and independent/autonomous practice get blurred.

State Advocacy Agenda
The Six Key Elements of a Modern PA Law

- Licensure as the regulatory term
- Full prescriptive authority
- Scope of practice determined at the practice
- No ratio restriction
- No co-signature requirement in law
- Adaptable supervision requirements





In Addition

- Remove barriers to rapid deployment
- Add PAs to all relevant state laws
- PAs should be specifically named in Medicaid

PAs Need To Be Included In Policy Development

- Implementation work groups at the state level will benefit from inclusion of PAs
- State chapters need to be in close contact with governor's office and legislative leadership

What we should do right now

- Nominate PAs to State Health Commission, State Health Workforce Commission
- Look for opportunities to support PA education
- Review legislation for opportunities to promote PAs
- Remove all state law practice barriers
- Ensure full integration of PAs in new models of care.

"We were team before team was cool."

Jim Cawley, MPH, PA-C

AAPA's Strategic Plan – Learning from PAs

OPPORTUNITY AREAS | SUMMARY

1. Go beyond the elite
2. Embrace the leadership calling
3. Ignite the PA network
4. Unlock the PA brand
5. Support PAs to define their own path

Learning from PAs
What should AAPA keep in mind?

- Lead the Way
- Show Tangible Outcomes
- Be Transparent
- Stay Focused
- Be True to the PA Identity

State Advocacy Assistance – Call on Us!

- It's a little bit like clinical medicine – just when you think you've seen it all…
- Being a PA during times of system change can seem daunting – don't go there alone.
- AAPA is eager to help

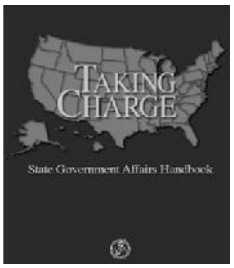
How can we help? We know people who know people…

We watch bills and regs – every day, every state, and DC, too!

We have policy, and can help shape policies of other organizations-

We can connect you to leaders in other constituent organizations who have done great things!

We have "how to" books and summaries and we can draft information specifically for your issue



We are creating new tools and services

Team Practice Statements

State by State Guide to PA Practice

We have a staff team to help you and your organization –

Carson Walker, JD, Policy Analyst, Liz Roe, MS, NC and SC States
Ann Davis, PA-C, Western States, Stephanie Radix, JD, SE States
Adam Brackemyre, MPP, NE States

Creative times call for creative solutions--

We need your input – let us know what the Academy can do for you.