Overview of Health Care Reform and ICD-10-CM updates; What an SLP needs to know

Jennifer Carotenuto, MPA, MS, CCC-SLP
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Change Is Inevitable?
Clear Skies Ahead for SLPs

Faster than average growth through 2018

Additional 22,100 SLPs needed

19% increase in job openings

Source: bls.gov
ASHA Numbers

- Over 150,000 SLPs, audiologist, and speech/hearing scientists represented by ASHA
  - Audiologists and hearing scientists = 14,000 with 9,400 in health care settings (72%)
  - Speech-Language Pathologists = 129,000 with 48,000 working in health care settings (38%)
SLPs in Health Care

Where we work

- Skilled nursing facilities 27%
- Outpatient clinic or office 24%
- Home health 19%
- General medical hospital 17%
- Rehabilitation hospital 8%
- Pediatric hospital 4%
- Other 1%
Post Acute Care is the Bull’s Eye!
Why Reform?

Figure 2. Medicare’s spending on post-acute care has more than doubled since 2001

Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.
How Much Do We Spend on Health Care?

- 2011 the US spent $2.7 Trillion
  - equates to $8,600 per person living in the United States
  - Another perspective: U.S. healthcare system’s economy is approximately as large as the economy of France.
Where Do We Spend Our Healthcare Dollars?

- 33% Inpatient care
- 22% Physician payments
- 10% Pharmaceuticals (fastest growing)
- 10% Administrative costs
- 10% Home health and nursing costs
- 11% Dental
- 4% Research
What Do We Get For Our Effort?

- US life expectancy (78.4 today up from 75.2 in 1990)… ranks 27th out of 34 industrialized countries

- Highest prevalence, or near highest prevalence of infant mortality, heart and lung disease, homicides and disabilities of 17 high income countries studied by NIH (2013)
What Do We Get For Our Effort?

- 2013 Bloomberg ranking of nations with most efficient healthcare systems, the US ranked 46th among the 48th countries included in the study.
Heath Care Basics

- Third party payers
  - Medicare (DRG, PPS)
  - Medicaid (DRG)
  - Private insurance (contracted rate usually similar to Medicare DRG/PPS rates)
  - Hillsborough County
- Private Pay
- No funding
Medicare-Federal Program

- Medicare is a Health Insurance Program for:
  - People age 65 or older.
  - People under age 65 with certain disabilities (disabled over 2 years).
  - People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

- Medicare has Two Parts:
  - Part A (Hospital Insurance) (no out of pocket expense)
  - Part B (Medical Insurance) (out of pocket monthly expense)
What Are the Numbers?

- 20% of all Medicare beneficiaries hospitalized at least once a year
  - Admitted for a wide range of reasons including medical, surgical, and functional diagnosis
  - About 35% of these patients discharged to PAC:
    - 41.1% to a SNF
    - 37.4% to home health
    - 10.3% to IRF
    - 9.1% to Outpatient/ambulatory therapy
    - 2.0% to LTACH
Medicaid Background

- Enacted in 1965 as part of the Title XIX of the Social Security Act
- Partnership program funded jointly between the States and Federal Government
- Beneficiaries include low-income families and children, pregnant women, the elderly, people with disabilities.
State Role in Medicaid

- Administers the program
- Determines eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets payment rates
Although Speech-Language pathology is optional under Medicaid, under EPSDT, States must provide service to children under 21.

Medically necessary services must be provided to individuals under 21, even if the service isn't available to the rest of the State’s population.
Healthcare Changes

- Movement over the last 20 years by Medicare to focus on outcomes and shift from fee-for-service health care industry
- Extended through the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act.
4 Major Themes of Health Care Reform

1. Expansion of coverage
   - ACA, Marketplace Exchanges, Medicaid Expansion

2. Collaborative models of care
   - Innovation program, bundling, ACOs

3. Payment changes and linking payment to quality
   - Value based purchasing, Medicare, Medicaid, private insurance

4. Program integrity
   - Claim audits, data mining
ACA Overview

- Patient Protection and Affordable Care Act of 2010 (ACA)
- Broad focus areas:
  - Improving health care quality
  - Shift towards outcomes
      - Goals: eliminating preventable health care acquired conditions, creating a more coordinated, less fragmented care delivery system, and using patient-reported information including personal goals and desired outcomes
ACA Overview

- Reducing fraud and abuse
  - Recovery Audit Contractors (RACs)
  - State Medicaid Fraud Control Unites- federal funds for data mining
  - Screening potential Medicare and Medicaid providers and suppliers
Marketplaces-Exchanges

- Organized marketplace for the purchase of health insurance
- People can compare health insurance plans, enroll in a plan, find out about available subsidies, and obtain customer support
- Initially offered to individuals and small employers; after 2017, states have the option to expand operation to include larger employers.
- States can set up their own exchange or default to the federal government exchange program
Essential Health Benefits

- 10 categories that must be included in policies offered in Exchanges and also by Medicaid
  - Ambulatory patient services
  - Prescription Drugs
  - Emergency Services
  - Rehabilitative and Habilitative Services and Devices
  - Hospitalization
  - Laboratory Services
  - Maternity and Newborn Care
  - Preventive and Wellness Services and Chronic Disease Management
  - Mental Health and Substance Use Disorder Services
  - Pediatric Services, Including Oral and Vision Care
Rehabilitation and Habilitation

- ASHA participated on a statutory working group formed by the NAIC to develop plain language definitions of insurance and medical terms and a standard summary of benefits form
- Released in proposed rule, to see the documents, go to http://naic.org/committees_b_consumer_information.htm
Rehabilitation

“Rehabilitation” was one term mandated in the law to be defined in the glossary.

Final definition

"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."
Centers for Medicare and Medicaid Innovation (CMMI)

- Established by the Affordable Care Act
- Mission: better care and better health at reduced costs through improvement. The Center will accomplish these goals by being a constructive and trustworthy partner in identifying, testing, and spreading new models of care and payment. We seek to provide
  - **Better health care:** by improving all aspects of patient care, including Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity
  - **Better health:** by encouraging healthier lifestyles and wider use of preventative care.
  - **Reduced costs:** by promoting preventative medicine, better record keeping, and improved coordination of health care services, as well as by reducing waste, inefficiency, and miscommunication.
CMMI Health Care Innovation Grants: Round 2

- Round 1 (May 2012) Consisted of 26 Projects that Would “Save Money, Deliver High Quality Medical Care and Enhance the Health Care Workforce”

- Round 2 (May 2013) Sought “New Payment/Care Delivery Models That Will Reduce Costs For Medicare, Medicaid, and CHIP Beneficiaries”
CMMI

- Projects that impact audiologists and SLPs
  - Support telehealth through model programs and demonstration projects
  - Oversee bundled payment model where the hospital is paid for inpatient stay and controls a specified duration of post-acute care
  - Develop an alternative to the therapy cap for Congress to consider
HITECH Act

- Health Information Technology for Economic and Clinical Health (HITECH) Act
  - Part of the American Recovery and Reinvestment Act of 2009
  - Promotes the adoption and meaningful use of health information technology
    - Incentives for providers to adopt EMRs
    - Monies for training centers to help develop and support IT infrastructure
  - Enhances and strengthens HIPAA regulations
Bundling Payments

- One payment shared by acute and post-acute programs and/or between hospitals and physicians and other professionals.
- Clinicians will be chosen for efficiency and ability to work collaboratively
- “autonomy” and those that “take time” will be left behind
Bundled Payments

Under a “bundled” payment model, providers receive a single payment for a defined set of services.
Bundling

- “Global episode of care”
- End of fee-for-service
- Goals are to improve price, quality, transparency, collaboration, reduce Medicare payments.
- Global payment includes both hospital and physician services for select ortho and cardiac procedures episodes of care.
- “value-based health care centers”
Bundled payment models

- Bundled payment models disincentivize the use of those providers whose services increase utilization and cost without adding perceived value.
- Clinicians will be chosen for the “bundle”
  - Produce results efficiently
  - Perform collaboratively
Bundled Payment Initiative
Under National Health Reform

CMS seeking applications October 2011 – March 2012

- Model 1: Acute hospital stay only
- Model 2: Hospital stay + post-acute care associated with the stay
- Model 3: Post-acute care only
- Model 4: Inpatient stay including all physician services, etc.
Bundling Payment Proposed Options

- MedPAC Bundling Proposal
- Chapter 3: Approaches to Bundling
- Payment for Post Acute Care
  - Longer Bundle: 90 Day Duration Post Discharge
  - Scope of Services: 4 Sites of Care + Physicians
  - Avoidable Readmissions
  - Payment Options: FFS Payment, Withhold Targets, Shared Savings
  - Quality Measures To Be Defined Would Tie Shared Savings to Quality
  - Services: Acute Care + SNF, IRH/U, LTCH, Outpatient + HHA - + Physicians
  - Avoid Stinting
Value Based Purchasing

- Providers accountable for both cost and quality of care.
- Patient outcomes and health status
- Goal is to reduce inappropriate care and to identify and reward the best-performing providers.
ACOs

- Accountable Care Organizations (ACOs) are a method of integrating local group physician practices with other members of the health care system and rewarding them for controlling costs and improving quality.

- Hospitals, primary care doctors, specialists and possibly even nursing homes and home care agencies would collaborate in an ACO, which would coordinate care and payment for care of participating patients.
ACOs

- Some compare the concept to a construction contract, with the ACO having the role of a general contractor and providers that of subcontractors.
- The theory is that there will be increased communication between providers, leading to better care and less duplication of services, such as laboratory tests, that will reduce overall health care costs.

(Thompson, M. *Post-Star*; 4-11-2010)
ACOs

- Instead of paying individually for each visit or medical procedure, Medicare or Medicaid would pay a set periodic payment, regardless of the amount of services, to the ACO, which would pass along proportionate payments to participating providers.
ACOs

1. An ACO may provide rehabilitation services with in-house staff, or contract with rehab provider organizations. An ACO may prefer to contract with a single rehab organization rather than separately with OT, PT, and SLP organizations.

2. Audiology services might be incorporated into rehab contracts, by independent audiology contracts, or through ENT practices that are ACO participants.
ACOs

- ASHA submitted comments in response to the proposed ACO regulations issued on April 7, 2011. ASHA urged CMS to require ACOs to:
  - Make speech-language pathology and audiology services accessible to patients. CMS responded that market forces will determine the need for the range of services offered.
  - Allocate an equitable portion of shared savings to speech-language pathologists and audiologists. CMS stated that it does not have legal authority to dictate how shared savings are distributed.
  - Encourage the use of telehealth services provided by audiologists and speech-language pathologists. In response, CMS announced that it is preparing a separate incentive package, not limited to ACOs, which includes telehealth services beyond what is currently reimbursed under fee-for-service Medicare.
Data Collection

- Data collection provides numbers to support the value of speech language pathology and audiology service.
- Currently, providers are collecting data for the NOMS and PQRS programs.
- CMS is adding another data collection form that will provide additional information about the services provided.
- This data will be used to determine the value of service and substantiate the need for continued and additional treatment.
ASHA NOMS

- CMS utilizes the National Outcomes Measurement System (NOMS) Functional Communication Measures (FCMs) to assess functional progress and outcomes
- official registry for outcome data to Medicare
Claims-Based Outcomes Reporting for Therapy Services

- CMS adopted 7 NOMS Functional Communication Measures for SLPs to report:
  - Swallowing
  - Motor Speech
  - Spoken Language Comprehension
  - Spoken Language Expression
  - Attention
  - Memory
  - Voice
- Additional code for “Other SLP Functional Limitation”
In 2010, private-practice **audiologists and speech-language pathologists** enrolled as Medicare providers began to participate in the Medicare Physician Quality Reporting System (PQRS)

PQRS is a voluntary program designed to improve the quality of care to Medicare beneficiaries.

- Private-practice health care professionals who participate in PQRS by reporting on approved quality measures are eligible for a 0.5% incentive payment from 2012-2014.
Speech CPT changes

- Effective 1-1-14
- CPT 92506 Evaluation of speech, language, voice, communication, and/or auditory processing replaced by:

  - 92521 Evaluation of speech fluency
    - e.g., stuttering, cluttering
  - 92522 Evaluation of speech sound production
    - e.g., articulation, phonological process, apraxia, dysarthria
  - 92523 Evaluation of speech sound production with evaluation of language comprehension and expression
    - e.g., articulation, phonological process, apraxia, dysarthria
    - e.g., receptive and expressive language
  - 92524 Behavioral and qualitative analysis of voice and resonance
Audits, audits, audits!

- Development of multiple Medicare/Medicaid auditing programs.
- MAC=Medicare audit contractors
- RAC=recovery audit contractors
RAs and MACs: Will This Torture Ever End?
What Can Providers Expect?

- Per the Advisory Board Company
  - Hospitals and other providers will see increased risk to revenue with shift to outcomes based focus
  - Bundled payments will reduce specialty care
  - Rewards in primary care will focus on coordination, chronic disease management, and population health
  - Total cost management will supplant fee-for-service incentives
  - New regulatory frameworks and entities to exist
Future of Health Care Reimbursement

- Opportunities for Quality Outcomes Measurement and Reporting
  - Value-based purchasing creates pressure to perform
  - Performance must be quantifiable
  - Development of metrics to measure all facets of health care performance will be a key element of the reform process and is funded by reform legislation
Future of Health Care Reimbursement

- More robust measures of clinical quality and outcomes will emerge, including:
  - Health outcomes and functional status of patients
  - Management and coordination of care across episodes of care and provider settings
  - Care transitions for patients across the continuum of providers, health care settings, and health plans.
Forecast & Outlook for the Preparation of Future SLPs

- Move to team-based care
- Focus on interprofessional collaboration
- Need to present a solid identity
- Introduction of new teaching technologies
- Need to assess cost of/ access to health care
- In God We Trust – everyone else bring data
- Use of online simulation
Future of Health Care Reimbursement

- Speech-language pathologists and audiologists will be increasingly paid for patient outcomes (value-based purchasing) rather than volume of visits, number of sessions, or number of tests.
Future of Health Care Reimbursement

- Medicare’s current fee-for-service payment systems, which pay on the basis of quantity and consumption of resources, do not support this vision for quality health care.

- **Value-based purchasing (VBP)** aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality.
Future of Health Care Reimbursement

- Over the last 20 years, Congress and presidential administrations have moved Medicare from prospective payment systems to value-based health care purchasing initiatives (paying for results) rather than the number of tests or services, regardless of outcomes.

- The Patient Protection and Affordable Care Act (ACA) sends a strong signal that QUALITY will be a central driver of health care reform changes.
More Changes!

ICD-10 CM
ICD-10-CM

- International Classification of Diseases, 10th Revision, Clinical Modification
- Required October 1, 2014
- Will include CM (clinical modification) and PCS (Procedure Coding System)
- Owned by the World Health Organization (WHO)
- Clinical modification was developed by the Centers for Disease Control and Prevention for use in all U.S. health care settings.
ICD-10 Purpose

- Standardize disease and procedure classification throughout the United States and to gather data about basic health statistics.
- HIPPA legislation mandates that ICD-10-CM be used for health services billing and record keeping.
Why update to ICD-10?

- ICD-9 was running out of codes as 100s of new codes are submitted annually.
- ICD-9 is more than 30 years old, has outdated and obsolete terminology, and produces limited data.
How is ICD-10 different?

- Based on alpha-numeric system vs. ICD-9 numeric only system.
- ICD-9 has 13,000 codes; ICD-10 has over 68,000 codes
- ICD-9 is general and 10 is VERY specific
Goals of ICD-10

- Provide better data for processing claims
- Assist with clinical decisions
- Help track public health
- Assist with conducting of research
- Identify fraud and abuse
Example

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Questions