

How the Passage of Federal Health System Reform Legislation Impacts Your Patients, Practice and Training Programs

■ Kristin Kroeger Ptakowski

Senior Deputy Executive Director and Director of Government Affairs and Clinical Affairs

On March 23, 2010, the President signed into law the *Patient Protection and Affordable Care Act* (ACA). Since the President signed the law in March, federal agencies, including the Departments of Health and Human Services, Labor, and Treasury, have been writing regulations to implement the law, and most work to date has focused on provisions that preserve access to health care coverage through insurance market reforms provisions that took effect on the sixth month anniversary of its passage. However, this is just the beginning, laying the groundwork for larger-scale reform. There are many more provisions left undefined that do not take effect for several years. AACAP has been commenting on individual provisions affecting our membership and your patients. These comments are on AACAP's web site at www.aacap.org/advocacy in our regulatory issues section.

This update summarizes provisions of the law that affect you, your patients, and child and adolescent psychiatry training programs. This is not meant to be an inclusive list of provisions, rather a glimpse of how children and child psychiatry fared in the passage of this act.

Insurance and Coverage Changes

- **Individual Mandate:** Requires individuals to have minimum coverage or pay a penalty. Families with incomes between 133 and 400 percent of the Federal Poverty Level (FPL) will be eligible for subsidies to help them purchase coverage on the exchanges. *Effective Date:* 2014.
- **No Preexisting Condition Exclusion:** No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion; also a temporary

insurance program has been created with financial assistance for those who have been uninsured for several months and have a pre-existing condition. *Effective Date:* 9/23/2010 or start of plan year for children; 1/1/2014 for adults.

- **Rescissions:** Bars insurers and group health plans from retroactively revoking health insurance coverage except in cases of fraud. Requires guaranteed renewability of coverage regardless of health status, utilization of health services, or any other related factor. *Effective Date:* 9/23/2010 or start of new plan year.
- **Lifetime and Annual Benefit Limits:** Health plans are prohibited from adopting lifetime or annual limits on the dollar amount of essential health benefits. *Effective:* 9/23/2010.
- **Patient Protections:** Guarantees individual and group health plan participants the right to select the primary care provider of their choice, so long as the provider participates in the plan and is accepting new patients. Prohibits health plans from charging different copays or coinsurance for emergency care received out of network. *Effective Date:* 9/23/2010 or start of new plan year.
- **Dependent Coverage Extension:** Parents may cover their dependent children up to age 26 on their health insurance plan. This includes foster children. *Effective Date:* 9/23/2010 or start of plan year.
- **Expansion of Medicaid and SCHIP:** All children in families with incomes under 133 percent of the Federal Poverty Level (133% of the 2010 FPL for a family of four is \$29,327). *Effective Date:* 2014 and onwards. States are required to maintain current income eligibility levels for CHIP through 2019.
- **State-Based Insurance Exchanges:** State-based insurance exchanges are intended to provide a central online marketplace for individuals and small businesses to purchase health insurance. HHS has announced the availability of \$51 million in grants. (\$1 million for each state) to begin planning. *Effective Date:* 1/1/2014.
- **Essential Benefit Package:** Any health plan must provide essential health benefits, in at least the following general categories plus the items and services covered within the categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care.
- **Preventive Services:** Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, and certain child preventive services recommended by the Health Resources and Services Administration, without any cost-sharing. This includes depression screenings for adolescents and screening for autism. *Effective Date:* 9/23/2010.

Incentives to Improve Workforce

- **Loan Repayment for Child and Adolescent Psychiatrists:** Establishes a loan repayment program for up to \$35K per year, for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population. *Effective Date:* when appropriated.

■ **Grants to Training Programs:** Provides grants to schools for development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. *Effective Date:* when appropriated.

Expansion of Access to Mental Health Care/Services/Research

■ **School-Based Health Clinics:** Authorizes a grant program for the operation and development of School-Based Health Clinics, which will provide comprehensive and accessible preventive and primary health care services to medically underserved children and families. Preference will go to communities that show barriers to primary and behavioral health services for children and youth. *Effective Date:* 2010-2013.

■ **Coordinated and Integrated Care:** Grants up to \$50 million for coordinated and integrated services

through the co-location of primary and specialty care in community-based mental and behavioral health settings. *Effective Date:* when appropriated.

■ **Youth Suicide Prevention:** Creation of a demonstration project to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth through the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment; training for frontline health care providers working with Indian youth; training and related support for community leaders, family members, and health and education workers who work with Indian youth; the development of culturally relevant educational materials on suicide; and data collection and reporting. *Effective Date:* 2010-2013.

■ **Centers of Excellence for Depression:** Creation of centers of excellence for the study of depression to translate academic treatment advances into clinical care and establish a

sustainable national resource for public and professional education and training.

Payment and Delivery reforms

■ **Psychiatric Services:** Increases the payment rate for psychiatric services by 5 percent for two years, through the end of 2010. *Effective Date:* Immediate.

■ **Quality Measure Incentives:** The law requires a mechanism under which a physician may provide data on quality measures through a Maintenance of Certification Program (MOCP) operated by a specialty body of the American Board of Medical Specialties (ABMS), with an additional 0.5% incentive payment for years 2011 through 2014 if certain requirements are met. These include satisfactorily submitting data on quality measures under the Physician Quality Reporting Initiative (PQRI) for a year and through the MOCP, and physicians must also participate in an MOCP for a year, more frequently than is required to qualify for or maintain Board certification status. *Effective Date:* 1/1/2011.

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IMPLEMENTATION									
2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
No Preexisting condition exclusion (children)									
No Lifetime and annual benefit limits									
Patient Protections and Rescissions									
Preventive Services Requirement									
Dependent Coverage Expansion									
Youth Suicide Prevention Funds									
School-Based Health Clinics									
EHR Incentives									
Quality Measure Incentives									
Affordable Care Organizations									
Physician Disclosures									
Medicaid Expansion to 133% poverty. SCHIP eligibility limits in effect.									
Individual Coverage Mandate									
Creation of State Insurance Exchanges									
No preexisting condition exclusion (adults)									
									Preventive care/check-ups without copayment

■ **Affordable Care Organizations:**

The law establishes a new Center for Medicare and Medicaid Innovation at CMS to help develop and implement new payment methodologies. The law specifically authorizes Medicare to contract with accountable care organizations (ACOs) — a new payment model to improve the coordination of care under networks of providers. *Effective Date: 1/1/2012.*

■ **Electronic Health Record Systems and E-Prescribing:**

The HITECH Act, adopted in 2009, provides many incentives for use of electronic health records. This bill is not officially part of the Affordable Care Act, but the same entities that developed the ACA package developed the HITECH package, and, in practice, federal agencies will coordinate HITECH Act implementation with ACA implementation, as if the HITECH Act were another part of the ACA package. The ACA 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. CMS

officials will wait until ACA programs are implemented before developing Stage 2 EHR adoption standards, and the ACA administrative simplification provisions aimed at health plans and health plan clearinghouses will probably help shape the EHR standards. *Effective Date: 1/1/2011* and on going.

Physician Disclosures

■ **Payments to Physicians and Teaching**

Hospitals: Require any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another transfer of \$10 or more value to a physician, a physician medical practice, a physician group practice, or a hospital with an approved medical residency training program to report quarterly to the Secretary of HHS. Payment means food, entertainment, gifts, consulting fees, honoraria, and other items or services of value.

■ **Research Funding:** Research funding also must be reported, but does not have to be disclosed publicly for

four years or until the product under development is approved, whichever comes first.

■ **Pubic Access:** The Secretary will publish this data in a searchable Web-based format. Physicians will have a chance to review and correct the information before it is released to the public. *Effective Date: 09/30/2013.*

Between now and 2014, there will be regulations written about new reporting and compliance requirements, increased incentives for streamlining administrative processes through electronic health records and e-prescribing, as well as incentives to join ACOs or patient centered homes. There are likely to be changes to reimbursement process and practice through quality measures. AACAP will continue to monitor the developing regulations and work with agencies, as well as our leadership and components, to ensure child and adolescent psychiatrists' needs and concerns are included, together with funding for the provisions we worked hard to get into the law. If you have any questions, please contact Kristin Kroeger Ptakowski at kkroeger@aacap.org. ■