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The Impact of the Affordable Care Act on Occupational Therapy Private Practice

Occupational Therapy Honors in the Discipline

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Elizabethtown College 2016

Abstract

The passage of the Affordable Care Act (ACA) in 2010 marked a substantial evolution of the health care system in the United States (The Executive Office of the President of the United States, 2014). There was a considerable amount of literature speculating on the proposed effects of the Affordable Care Act on occupational therapy (American Occupational Therapy Association, 2014a; Braveman & Metzler, 2012); however, little evidence exists regarding the outcomes of the ACA especially for occupational therapists in private practice. The present study aims to examine the implications of the Affordable Care Act on private practice occupational therapy.

Through interviews with seven occupational therapists in private practice, researchers used content analysis to extract themes within interviews. Analysis of interviews identified various effects of the ACA on occupational therapists in private practice including, but not limited to, trends in prevention, increased cost-sharing to consumers and decreased utilization, no Accountable Care Organization participation from any participant, increased insurance complexities, increased need to stay informed and advocate for OT to consumers, and increased time and finances required to maintain practice.

The Impact of the Affordable Care Act on Occupational Therapy Private Practice

Introduction

The passage of the Affordable Care Act (ACA) marked a substantial evolution of the health care system in the United States (The Executive Office of the President of the United States, 2014). Signed into law March 23rd, 2010, the ACA is a legislative health care reform that contains over 11,000 pages designed to alter and change the delivery and financing of the health care in the U.S (Hetherington, 2014). The main goal of the ACA is to provide access, high quality, and affordable health care to uninsured Americans (Patient Protection and Affordable Care Act, 2010). There is much speculation surrounding the direction of the health care industry. A challenge exists in projecting the outcome of the ACA and the effect it may have on both the population it serves, and the health care services that accompany them (Hall, 2014). While the rehabilitative field has felt the impacts from many provisions of the ACA, this study will focus on occupational therapy (OT), specifically private practice.

Background & Literature Review

The Affordable Care Act and Occupational Therapy

The ACA marked the largest health care system reform since the passage of Medicare and Medicaid in 1965 (CMS, 2015). The ACA sought to change many areas of the U.S. health care system including habilitative and rehabilitative services such as OT (PPACA, 2010). Specific provisions of greatest impact include expanding health care coverage, reducing costs of care, guaranteeing essential health benefits, creating new regulations for insurance policies, and expanding Medicare and Medicaid (PPACA, 2010).

The ACA expanded coverage in multiple ways. First and foremost, the income bracket for Medicaid recipients was expanded to allow more individuals to be covered through this pre-existing government insurance for low-income individuals and families. In 2014 states were mandated to expand Medicaid to children ages 6 to 18 in households with an income up to 138% of the Federal Poverty Level ([FPL], [PPACA, 2010]). Prior to this, the limit for Medicaid coverage was 100% FPL (Musumeci, 2014). If a state did not comply, the state would lose all of their existing federal Medicaid funds (Musumeci, 2014). The ACA also had a provision to mandate states to expand Medicaid eligibility to single adults up to 138% FPL (PPACA, 2010). In June of 2012, the Supreme Court deemed both of these mandates unconstitutional and instead gave states discretion to choose whether or not to expand their Medicaid programs without fear of losing all of the state's Federal Medicaid funds (Musumeci, 2014). Ultimately, states have a mixture of Medicaid policy as related to this provision of the Affordable Care Act. With an increase in the FPL in terms of coverage for Medicaid, the goal is to increase the number of individuals covered by this program. Because Medicaid covers inpatient and outpatient services (Hall, 2014) including occupational therapy, there will likely be more consumers of occupational therapy.

The ACA also expanded coverage by mandating insurers to alter certain policies, or add additional policies to new health plans. These changes included allowing young adults to stay on their parents' health care plans until the age of 26, eliminating lifetime coverage caps, and making the practice of denying someone based on pre-existing conditions illegal (White House, 2015). The law also created state-run insurance marketplaces and exchanges where individuals can shop for insurance and compare different plans, giving

consumers choices (White House, 2015). Preliminary evidence suggests that insurance premiums on the exchange marketplace are similar to or at a lower cost than insurance premium rates that insurers offer to employer groups (Kronick & Skopec, 2014). These policy changes have the potential to increase the number of persons seeking occupational therapy services, therefore possibly providing more opportunities for occupational therapy.

Lastly, the ACA mandated both individuals and employers to have or provide health insurance (PPACA, 2010). The first of the two is known as the individual mandate, which requires individuals to have minimum essential coverage or pay an annual fee (PPACA, 2010) This fee is calculated one of two ways - either a percentage of income, or on a per person basis, whichever is higher (PPACA, 2010). The second of the two is the employer mandate. Companies that have 50 or more employees are required to offer affordable coverage to 95% of full-time employees and dependents. If companies fail to comply, fines may occur (Health care.gov, 2015). Again, the implications for occupational therapy include a potential increase in individuals insured and number of persons seeking OT services.

Prior to the passage of the ACA, 50.7 million Americans were uninsured (The Executive Office of the President of the U.S., 2014). According to the U.S. Department of Health and Human Services (2015), as of September 2015, nearly 5 years since its passage, a net total of 17.6 million people have been newly enrolled. Expanding coverage for individuals increased the amount of consumers in the health care system and the demand for health care resources and services (Anderson, 2014). At the same time, a press release from the Conference Board, a company specializing in international market trends,

also reported that U.S. will likely see shortages in three main labor areas: health-related occupations; skilled labor; and jobs in science, technology, engineering, and mathematics (American Physical Therapy Association [APTA], 2014). The report specifically cited OT and physical therapy as a concern for shortages within health-related occupations (APTA, 2014). In addition, according to the U.S. Department of Labor (2014), the job outlook for occupational therapists from 2014-2024 is an increase of 27%, which is “much faster than average” (para. 1). The increase in consumers is likely one of the causes for the increase in demand for health care resources and services including OT.

Improving quality of care while reducing costs of care is one of the main hurdles of health care. The ACA attempts to offer solutions to this important issue. One of these solutions includes forming Accountable Care Organizations ([ACO], PPACA, 2010). The ACA established ACOs as a new payment model for Medicare that focuses on integrating networks of providers including hospitals, outpatient clinics, physicians and physician groups, inpatient rehabilitation clinics, long-term care hospitals, and private practitioners such as occupational therapists (CMS, 2015). These providers agree to share the cost, quality, and outcomes of the services provided to their patients (AOTA, 2012). This government initiative only applies to Medicare beneficiaries who are currently receiving fee for service coverage. The aim of the payment model is to increase quality and outcome of care, guarantee patient satisfaction of care, and measure efficiency (CMS, 2015).

There are several methods ACOs employ which include providing financial incentives to health care providers such as hospitals, long term facilities, and outpatient facilities to work together to coordinate care, bundling payments of health care services to control costs (PPACA, 2010), implementing the use of electronic health records (Hall,

2014), and providing financial incentives for improved quality of care and reduction in re-admissions (PPACA, 2010). The goal of an ACO provider is to efficiently utilize the most effective resources and services while minimizing costs through initiatives such as decreasing duplication of services, shortening the length of stay in the hospital, reduction in readmissions, disease/accident prevention, and effective discharge planning (Mayer, 2013).

An ACO is able to form as long as three main criteria are met. According to the Centers for Medicare and Medicaid (2015), the criteria include patient population of at least 5,000 Medicare recipients, agree to remain an ACO for at least 3 years, and maintain a governing body. The network formed by the involved entities creates a system in which electronic health records (EHRs) are uniform and can be shared among providers, thus reducing the duplication of services and increasing communication (CMS, 2015). An initiative before the ACA known as the American Recovery and Reinvestment Act (ARRA) also encouraged the use of EHRs by providing financial incentives to physicians, hospitals, and other health care providers that implemented them (FCC, 2009). Although the importance of EHRs has been stressed within the ARRA and ACA, Hall (2014) surmised that EHRs have been particularly problematic. According to a survey conducted in 2013, 86% of chief information officers at hospitals felt pressured to “forge ahead with a project that was fraught with errors” (Gamble, 2013, para. 1). Hall (2014) explained that implementing comprehensive electronic record systems causes substantial disruptions within a facility, as well as significant costs. For example, an electronic health records system failed at Sutter Health in Northern California after the facility recently spent one billion dollars on the technology (Hall, 2014). Medical staff including nurses, physicians,

case workers, therapists and more were left an entire day without access to the patient's medical records causing major issues within the hospital (Hall, 2014). This occurrence reflected the need to ensure systems are adequate before implementation.

The creation of ACOs reflects an increasing emphasis on functional outcomes and preventative services in the U.S. health care system. Occupational therapists have a defined role in disease and accident prevention, and function. The impact of ACOs on OT has been primarily investigated in the inpatient setting (Nyweide, et. al., 2015). Nyweide et. al. (2015) reported that an ACO model saved nearly \$23.40 on average, per patient, in comparison to other fee-for-service Medicare beneficiaries not aligned with an ACO. Nyweide et al. (2015) further found the largest savings difference in spending in the inpatient setting. The study also included two groups that private practice OT could be included in such as *hospital outpatient* and *home health*, although it is uncertain the specific nature of these services (Nyweide et. al., 2015). This study suggests that the ACO model has the greatest impact on efficiency and cost reduction in the inpatient setting, which could include inpatient OT. There is no evidence from this study, however, to suggest the ACO model impacted private practice OT.

The final provision of the ACA that has the greatest impact to OT is the creation of essential health benefits (EHB) that health care plans must cover (PPACA, 2010). Essential health benefits ensure that individuals have a minimum level of health insurance covering certain services and resources (Brown, 2014). One of the ten broad EHB categories is *rehabilitative and habilitative services and devices* and specifically states OT as a provider (AOTA, 2014a). This provision made it essential that OT services were covered under individual's health insurance plans (AOTA, 2014a). In addition, two other

EHB categories have the potential to include OT: mental health and substance use disorder services, including behavioral health treatment, preventative and wellness services, and chronic disease management (Metzler, 2012). The defined scope and extent of the main essential health benefits varies from state to state (Rifkin, 2013). Therefore, Rifkin (2013) explained opportunities for therapists will vary based on the operational definition of essential health benefits within their respective states. According to Brown (2014), the EHB provision not only cements OT's role in health care, but also provides a pathway for the expansion of OT services covered. Essential health benefits will likely ensure that coverage for occupational therapy services will continue to be covered by insurers in the future with the possibility of expanded opportunities.

As previously stated, the ACA created substantial legislative changes to the content and delivery of the U.S. health care system. According to Fisher and Friesema (2013), the complexities of the ACA require consumers of health services to have skills in health literacy. Health literacy is defined as the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Kutner, Greenburg, Jin, Paulsen, & White, 2016, p. iii). Fisher and Friesema (2013) believe that health literacy skills can greatly affect the outcomes of patient care, and that occupational therapists can ensure both consumers and providers understand its implications. Negative effects of patients with low health literacy skills include noncompliance with recommendations, underutilization of services, and increased hospitalizations (Fisher & Friesema, 2013). Smith, Hendrick, Earhart, Galloway, and Arndt (2010) studied the implications of decreased health literacy within a rehabilitation center and independent living facility. Their findings concluded that

difficulty understanding health information can lead to a person's increase in hospital emergency services, decrease usage of preventative services, decreased overall mental and physical health, and even a higher risk of death (Smith et. al., 2010). These findings indicate that comprehension of the many facets of the ACA is important for the overall health of an individual, and that occupational therapists can play an active role in improving health literacy in regards to the ACA.

Potential Effects of Affordable Care Act on Private Practitioners

There are numerous definitions for general private practice and occupational therapy private practice. The Medical Dictionary (2009) definition states that private practice within the health care setting includes a professional or multiple professionals that are "independent of external policy control other than ethics of the professional and state licensing laws" (para. 2). The American Occupational Therapy Association (AOTA) described a private practice within the OT setting as a person, or group of people, that is/are interested in private practice to "create a business that receives payment for OT services directly or on behalf of the client/patient/ or consumer" (AOTA, 2011). The American Occupational Therapy Association (2011) also stated the professional must be "licensed, certified, or registered as a therapist to engage in (OT) private practice."

The ACA has increased the role that the public sector has on health care. As the interplay between the public and private sector grows and alters, there are potential challenges as well as areas of opportunity for private practitioners. The potential challenges that private practices face due to the implementation of the ACA include increased clientele and populations to serve, decreased patient interaction, increased documentation and billing time, reduced reimbursement, decreased income and revenues,

conversion to electronic health records, formation of compliance and reporting measures, annual patient insurance coverage changes, and increased competition (Anderson, 2014, Shi & Singh, 2015).

Many of the potential challenges that private practices may face are highly interrelated. For example, since the implementation of the ACA, 17.6 million additional people have health care coverage (DHHS, 2015). The increase in the number insured has the potential to increase clientele for private practice, which, according to Anderson (2014) and Hall (2014), could increase billing and documentation time; this can also be attributed to new policy changes such as quality measures and electronic health records. Increased billing and documentation may lead to reduced time with the patient, which may affect the quality of service delivery and decreased reimbursement (Anderson, 2014). Several of these potential challenges have been observed among groups of private physician practitioners.

In 2010, 3-4 months after the ACA became law, The Physicians Foundation found that 89% of survey respondents felt that the traditional model of independent private practice is either “on shaky ground” or soon to become extinct (Phillip & Thrall, 2010). The survey highlighted the need for private practices to adapt to the changing health care environment. Nearly two years later in 2012, MDlinx, found that 53.1% of physicians in independent or small practices reported drops in their incomes, and one-third of those individuals said they expected the trend to continue. Twenty-six percent of these small private practice respondents were also worried about the possibility of losing their practice within a year (Jones, 2012). Effects on physician practices indicate that independent private practice may be at risk in the future.

Although challenges exist, there are many potential opportunities for private practitioners under the ACA. These opportunities include expanding traditional services provided, receiving reimbursement for new services such as preventative/wellness services, Medicare-funded wellness visits, increased funding for certain populations, increased clientele, and the potential for increased revenues (Braveman & Metzler, 2012). Braveman & Metzler (2012) speculated that it is up to the health care providers to take initiative and look for potential opportunities in the changing health care system. According to Hetherington (2014), entrepreneurs are agents of innovation and can facilitate cohesive change in a way that large networks often struggle to accomplish. Similarly, Rifkin (2013) and Persch, Braveman & Metzler (2013) believe that practitioners will play a pivotal role in the evolving future of healthcare as long as they advocate for the profession. Specific areas of advocacy include working closely with professional organizations (Hetherington, 2014), communication among private practitioners, and utilizing data to support interventions and documentation (Persch et. al., 2013; Rifkin, 2013).

Summary

The main portions of the ACA that may potentially affect private practice include increasing health care coverage, improving quality of care, reducing costs of care, guaranteeing essential health benefits, creating new regulations for insurance policies, expanding Medicare and Medicaid, focusing on disease prevention, and creating Accountable Care Organizations. While there were many predictions on the impact that the ACA may or may not have had on health care, there has been little evidence provided on actual outcomes, including the OT profession. Much of the literature discussing OT

and the ACA highlight points of the law that may affect OT. Many of the researchers also pinpoint areas of growth and opportunity for the field as well as possible threats. The sparse information involves settings such as acute care, but there is virtually no information on private practices. Thus, this study sought to explore the effects of the ACA on private practice OT. The research questions for this study were: Do the provisions of the ACA impact occupational therapy private practice? If so, in what way do the provisions affect private OT practice?

Methodology

The research study (831168-1) was reviewed and approved by the Elizabethtown College Institutional Review Board. In keeping with the IRB, names of participants were changed to protect confidentiality.

Research Design & Procedures

The present study was an exploratory, qualitative research design. Research was conducted through in-depth interviews with private practitioners. Recruitment of therapists was achieved through a variety of means including snowball sampling, emails to pre-established contacts of faculty, posts on the American Occupational Therapy Association's research board, and social media outreach.

Criteria for participants included the ability to give consent, being over the age of 25 (this assumes some clinical experience), and meeting the standards for our defined scope of a private practitioner as formulated through the literature. For the sake of this research study, private practice within the scope of OT was operationally defined as a person or persons who receive payment for OT services directly, or on behalf of a

client/patient, and is/are independent of external policy control other than the ethics of the professional and state licensing laws. In addition, the person or persons must be licensed, certified, or registered as a therapist to engage in OT private practice. Each participant in the study gave written and verbal consent. Consent forms were either individual- or site-based, dependent upon whether the participant was the owner of the practice. The informed consent documents were kept in the study advisor's locked file drawer.

Semi-structured interviews were conducted via phone or Skype™ in order to gain information on the following points: the varying nature of private practices, the effects of the ACA's provisions on billing, reimbursement, Medicaid expansion, etc., and the views of occupational therapists on the direction of private practice. Appendix A shows the complete listing of questions asked during the interviews.

Interviews were scheduled at the convenience of the interviewee. Interviews lasted from 12 minutes to 30 minutes. One researcher transcribed an interview and the other researcher then reviewed the transcript for accuracy with the recording; this helped ensure credibility with data collection. Data remained confidential by omitting names and business names associated with the participants. Numbers were used to protect the identity of participants. No identifiers were included in the research study. In addition, audio recordings were removed from recording devices after transcription, and the audio files were stored on a flash drive in the advisor's locked file drawer. At the end of the study, the transcripts were given to the researchers' advisor to keep in a locked file drawer in a locked office.

Participants

It is hard to estimate the number of potential participants for this study because discussion forums do not state their membership sizes, and social media has an undetermined outreach. Eleven individuals responded to recruitment methods. Of these, four individuals responded via email stating that due to the nature of their pediatric private practice, they did not think that they should participate in the study. These therapists believed their practices were not affected by the ACA. However, seven participants completed interviews for this study. Of the seven participants, one was a male, and six were females. Table 1 describes the participants, their assigned numbers, and a brief description of their role in private practice.

Table 1

Participant Description

Participant	Role in the practice
1	Director of private practice – 19 locations and 45 staff members
2	Founder of a pediatric private practice who serves mainly early intervention – staff of 5
3	Clinical supervisor at a pediatric private practice – staff of 10, multi-disciplinary
4	Partner/founder of a hand therapy private practice clinic
5	Partner/founder of a home modification/aging in place private practice
6	Partner/founder of an outpatient rehabilitation clinic – mainly hand therapy
7	Founder of a pediatric private practice

Data Analysis

Researchers examined the transcripts for common themes by participants using content analysis. Researchers identified themes by first reading transcriptions independently, and collaborating on discovered themes. This provided a high degree of inter-rater reliability and consensus validation for common themes. The themes that all researchers found through independent analysis of the transcripts were coined as primary themes. Themes that two, but not all three researchers found were coined as secondary results.

Results

Six primary themes emerged following analysis by the three researchers: trends in prevention, increased cost-sharing to consumers and decreased utilization of health services, no Accountable Care Organization (ACO) participation, increased insurance complexities, increased need to stay informed and advocate for OT to consumers, and increased time and finances required to maintain practice. Secondary results included increased demand for services for some but not all practice settings, less impact on providers who do not accept insurance, and differing effects on different settings.

Trends in Prevention

Many interviewees shared a positive outlook for opportunities involving prevention, however many questioned their ability to be reimbursed for preventative services. While some participants were able to bill insurances for preventative services, many expressed a hope for growth in that direction.

Whether or not prevention was helping their revenues or reimbursements, several participants expressed positive feelings toward the trend of prevention. Participant 4

stated, “I think there has been a good trend toward prevention and that’s been something I think that is a positive.” Similarly, participant 2 explained parts of the ACA as, “...there are little gems embedded in that legislation. And one of those gems is that shift to focus on prevention and wellness.” Participant 6 explained the trend toward prevention as,

“With Medicare, it’s something called PQRS [Physician Quality Reporting System], which is a reporting system that we have to report on a patient’s BMI [body mass index], if they’ve fallen in the last year, if they’re feeling depressed, how much they drink, if they smoke, and that’s all geared at preventative. And you know we have to record that with our claims and billing.”

While this preventative service does not necessarily directly reflect participant 6’s direct practice as a mainly orthopedic rehabilitation practice, it does show that OTs are able to apply clinical judgment skills to a direct reporting system for Medicare. Participant 6 not only highlighted a preventative part of their intervention at the private practice, but also the potential for OTs to play an integral role in their client’s wellness in the future. Participant 1 also was able to bill for preventative services that the practice offers such as,

“We have a more social cultural emotional physical perspective on everyone and what we can offer. So we are looking at wellness programs, fall prevention, obesity reduction activities, throwing programs, music injury prevention, music programs like that.”

Participant 1 was the only practice able to bill for some type of preventative service. Clinicians from other areas of practice, however, were still struggling to find ways

to embed prevention into their billable services. Participant 2 said, “I would love to start finding a way for OTs to get paid for prevention and wellness.”

Correspondingly, participant 3 stated, “It’s an area that I would love to do more in.” Participant 3 also explained that, “The owner of this company has just begun to offer one week free screenings for families who suspect there might be something wrong, but they are not 100% sure.” However, it should be noted that these screenings are provided for free and there is no type of reimbursement at this time.

Increased Cost-Sharing to Consumers and Decreased Utilization of Services

While much of the ACA aims to increase the number of insured individuals in the United States of America, the shift in responsibility of cost from insurance company to consumer has at times decreased the utilization of healthcare services. The number of insured has increased, but the choice to use insurance in turn has declined. Many participants voiced statements mirroring a lack of routine therapy schedules due to the increased cost-sharing on consumers.

Participant 4 believed that the ACA has decreased their practice’s overall clientele because, “everyone now has a much higher deductible as their commercial insurance and they have fewer visits and higher co-pays.” As a result of higher deductibles and co-pays, participant 4 stated she noticed several instances where, “people who are getting less treatment who are perhaps coming for a shorter period of time to therapy, being discharged or discharging themselves before they are completely better.” Participant 2 discussed the change in cost-sharing and utilization of healthcare services by stating that, “because they have a more affordable plan, their out of pocket is increased, then they may decline services that the child needs because they can’t afford it.” Similarly, participant 4

said, "...everyone now has a much higher deductible as their commercial insurance and they have fewer visits and higher co-pays. So there's an obviously much higher cost to the patient." Participant 4 restated this thought a second time when discussing insurance companies, "They've moved the burden of payment from themselves to patients."

When explaining the number of individuals receiving services from the practice after being insured through the exchange, participant 6 stated, "I think the few people we have had have been a one-time only visit because they have \$90 co-pays and \$6500 deductibles so it might give them access in theory but they can't afford that." In order to combat the decreased number of follow-up visits, participant 1 said, "We are doing a whole lot more, very heavy home teaching. We are starting to move into tele-health and it's not reimbursable yet, but we are setting up ways to do [this]."

These direct quotes from this study's participants reflect that while individuals have received insurance as a result of the ACA, many of those plans put the burden of payment onto consumers which may lead to a lack of or decreased healthcare service participation. Some clinicians have changed their therapy in order to meet these new needs via home programs and the possibility of tele-health.

No Accountable Care Organization (ACO) Participation

Another key finding of this study is that none of the seven participants were part of an ACO. There were several different reasons behind the lack of ACO cooperation such as it not being appropriate given the nature of the individual's business or a general fear of bundled payments between healthcare services. Several participants were not participating in ACOs because they are from out-of-network practices.

For those participants who were considered in-network practices, they feared ACO participation could ultimately lead to bundling of fees from insurances for physicians, therapies, and other healthcare professionals to treat a client. Participant 6 spoke of ACOs and said, “The problem is with those, in my opinion, is they are pitting healthcare providers against each other.” From this, the clinician explained the belief that bundling costs would ultimately lead to conflicts between service providers for reimbursement. Participant 6 also added, “I have not seen that in our area and hopefully I don’t, if that’s the case,” when speaking of the prevalence of ACOs.

Participant 1 described ACOs as, “They are like monster organizations, they are gigantic.” This participant stated the practice is able to maintain relationships with several different groups of physicians and prefers to align the practice in that way rather than a binding contract.

Increased Insurance Complexities

Participants also discussed the increased intricacies surrounding both public and private insurances. Among these complexities are managing changes in annual coverage, less coverage, restrictions within insurance coverage, and issues with reimbursement from Medicare and Medicaid. In regard to alterations in clients’ insurance carriers, participant 2 said, “Every January 1st, we are trying to find out if everybody still has the same insurance.” Their practice must spend time each new year tracking changes in policies, coverage, reimbursement as their clients may change plans.

There were reported challenges with reimbursement. Participant 3 stated, “I have seen families having less and less reimbursement for out of network insurance.” Another interviewee, participant 7, said, “It’s very challenging to get reimbursements and they try

to make it as challenging as possible for the families.” Both participant 3 and 7 reflected the issues confronting out-of-network practices. However, this issue spans from out-of-network practices to in-network practices. This was exemplified by participant 1’s statement, “Reimbursement has gone down...so there are cuts in what we used to do for the same service.”

In regard to publicly-funded insurances such as Medicaid, participant 6 discussed their practice’s experience by stating, “We do not accept any Medicaid products, so no. We used to and then they never paid us so as a private practitioner you can’t see people for free so we don’t see any Medicaid.” Participant 2 explained the potential effects of Medicaid increasing the Federal Poverty Level (FPL) to 138% by saying, “So as the Medicaid rate changes, then because they have a limited pool of money the state pulls from, sometimes they will change the eligibility criteria and they could either be more difficult or less difficult for kids to be eligible.” In other words, if the funding for Medicaid is cut, even with an increased FPL it may be harder for individuals to meet the regulations of Medicaid.

As the ACA’s provisions are put into action, there are indirect effects coupled with direct effects. Participants perceived insurance complexities as byproducts to ACA provisions, which directly or indirectly impacted third party payers.

Increased Need to Stay Informed and Advocate for OT to Consumers

With the changing healthcare system in the United States, there was a consistent theme throughout the seven interviews – OTs must maintain their uniqueness and advocate for the profession in order to stay viable. Participants viewed the ACA as an area for growth for the OT profession if clinicians take initiative. Participant 5 said,

“I think that there is a big opportunity for us to have private practices and if we continue to advocate for ourselves every opportunity that we have to promote OT every opportunity we have I think that there is a chance that ongoing changes in insurance company could hear us and they could write it into new policies. But we have to be out there as leaders and we have to be out there speaking up and supporting AOTA, who speaks up on our behalf, and we have to go to Capitol Hill Day every September and we have to advocate for those things because what happens too often is we get lumped into this grouping of PT [physical therapy] or people with orthopedic injuries get paid for and all the children with autism or the elderly with low-vision or the people who need a home modification evaluation, they’re not getting reimbursed.”

Participant 6 also voiced the idea of advocacy for the profession through stating, “OTs are going to have to be more vigilant of their practice act for each state and what they can and can’t do in order to defend their turf.”

Given the nature of our healthcare system, participants explained the importance of clinicians being educated. In explaining the added responsibility for clinicians to stay up-to-date on legislation or other things affecting the services they provide, participant 6 stated,

“The days are gone where you could just sit down and treat a patient and not be aware of the financial situations with the patient, with the clinic, and the costs of services. Those days are gone... if you want to be viable that’s for sure.”

Similarly, participant 7 discussed the need for OTs to remain sharp in their documentation skills and educated on the underlying principles or theories which lay the foundation of

their services. Participant 7 advised OTs to, “Feel confident in what you’re providing because more often than not you have to justify, for the families, what you’re doing and why you’re doing it.”

In a seemingly ever-changing healthcare system, it is imperative OTs take each opportunity to advocate for the profession in order to remain an integral part of healthcare. Clinicians must maintain a high expectation for themselves in terms of quality of service, responsible care, and exercising therapeutic knowledge as a basis for all areas of practice. Legislation continues to be formed on the topic of healthcare and OTs must educate themselves and be aware of changes.

Increased Time and Finances Required to Maintain Practice

Resulting from many of the previous themes, private practitioners stated a need to allot more time and/or finances due to the ACA. Our participants were split – half chose to outsource billing or hire a billing agent while others completed their own billing and administrative tasks. Even without the responsibility of billing insurances or clients directly, participants explained the increased attention given to documenting the OT process.

Participant 1 outsourced the practice’s billing, but also made note that, “... But there is a lot of tracking and paperwork information that we need to do, and so it takes longer away from clients... So it is harder to, more expense for the service for me, for the overhead.” Therefore, even though their clinicians do not have to directly complete their billing, the documentation for clients ultimately leads to a decrease in productivity for clinicians. This decreased productivity causes reduced revenues for the practice when compared to previous documentation requirements.

Participant 4's practice previously had secretaries, but because billing is so complicated, the partners decided to take on the responsibility of billing to ensure accuracy. However, when describing trying to monitor payments from insurance companies, participant 4 said, "So much of my time is devoted to fixing errors because there are so many." Because the partners must spend excessive amounts of time making sure their claims are accepted and services are being reimbursed, they spend less time with clients. As a result of ACA provisions, participant 6 explained, "So we've had to outsource our billing which I'm not happy about because that costs extra money." This issue is a two-fold; if practices choose to maintain responsibility for billing they decrease productivity, but outsourcing is an added financial expense to practices.

Secondary Results

While these findings were not consistent among all researchers, it should be noted that the interviews yielded secondary results. Secondary results included the increased demand for services for some participants' practices, an observed smaller impact on providers who do not accept insurances, and differing effects on different settings.

Some, but not all, participants discussed the increased demand for their services. Participant 1, for example, said, "The general increase in demand of services had been about 22% for our practices since the integration of the Affordable Care Act." Another participant whose practice was experiencing an increased demand was participant 2 who stated, "I am turning away maybe 50 referrals a week." However, this idea was not seen throughout the majority of participants.

As stated previously, our participants included both in-network and out-of-network practices. While many themes were applicable across regardless of insurance participation,

there was a notably smaller impact on those practices which did not accept insurance reimbursements. These practices are out-of-network and are paid directly out of pocket by consumers for service; therefore they do not bill any insurance companies for their therapeutic evaluations, interventions, etc. Practices out-of-network stated not needing to educate themselves as heavily on the ACA because their practices did not depend on the contracts put forth by clients' insurance policies. While some out-of-network private practitioners assisted clients in submitting claims to insurances for reimbursement, these practices did not need the same amount of time or finances which are required to be affiliated with insurance companies.

The study's participants were extremely diverse in terms of setting. Following the analysis of all transcripts, researchers noted that the practice setting seemed to dictate the different effects of the implications of the ACA. Variations in populations served lead to mixed implications. Sources of referrals differ based on the population which ultimately leads to difference in reimbursements based on government-funded entitlement programs (early intervention/Medicaid) for pediatric populations while in-network traditional rehabilitation practices receive more payments from private insurances.

Discussion

This study aimed to identify if 1.) The ACA had an impact on occupational therapy private practice, and 2.) If so, what were these impacts? From the results of the study, it can be concluded that the ACA has had an impact on private practice occupational therapy in a variety of ways.

Our participants mirrored evidence in the literature (Braveman & Metzler, 2012) by noting there is room for growth, positive opportunity, and expanding the role of OT

under the ACA if therapists continue to advocate for the profession. Because participants stressed advocacy for the continued growth of the OT profession, it is evident that the areas of opportunity and challenges which were highlighted throughout the literature are being noted throughout private practitioners. Potential areas for growth from both the literature and our interviews include reimbursement for preventative services and potential for increased responsibility within the healthcare team (Braveman & Metzler, 2012). Interviews and literature both discussed areas which may limit OT which include loss of revenue, decreased reimbursement, and decreased direct contact with clients (Anderson, 2014, Shi & Singh, 2015). Without advocacy from within the profession, OT practices may risk a loss of autonomy and ability to give proper services.

Prevention was a specific area of interest seen among the participants in the study, but only one practitioner was receiving third-party reimbursement for preventative services. With prevention stressed so heavily in within the ACA, a question must be raised as to why these services are not being covered or implemented as would be expected within this setting. Reimbursement for prevention and wellness is closely linked with primary care and the mechanisms of addressing day-to-day health concerns. According to AOTA (2014b), occupational therapists have the skills and abilities to be members of interprofessional primary care teams. In addition, AOTA (2014b) states that new models of primary care delivery are expected to be the most effective strategies for addressing chronic health concerns, rising health care costs, and increased health and wellness of the population. It seems that the profession of OT recognizes the need and opportunity in primary care and prevention and wellness, but the lack of reimbursement seen by the

participants suggests that these new primary care models have yet to be fully implemented.

Based on the results of the study, provisions expanding Medicaid may affect pediatric services more than other practices. In contrast, provisions which incorporate wellness into Medicare treatment teams as well as changes in required documentation for Medicare and the ACA may affect traditional rehabilitation practices more than those who serve pediatric populations. Four OTs also responded and declined to participate in the study because they felt that their pediatric practices were not affected by the ACA. Evidence highlights the likelihood that pediatric practices may be affected differently than traditional rehabilitation private practice.

According to the ACA (2010), one of its major provisions is the formation of ACO networks among health care providers. Nyweide et. al. (2015) found ACOs to be effective in cost savings, but none of the private practitioners interviewed are part of one. Possible factors for why this theme emerged include the complexities of joining, costs of conforming (EHRs, billing, etc.), competing interests, not having a defined need, and loss of uniqueness. Several participants in this study experienced increases in time and finances required to maintain their private practice. This could potentially place strains on private practices to stay viable. A similar theme was reflected in the literature (Jones, 2012; Phillips et. al., 2010). Evidence suggests that there is a need for OT private practices to align themselves within healthcare systems to maintain referral streams and to continue to participate in new payment and delivery systems.

Increased insurance complexities seemed to be a driving force behind many of the impacts on private practitioners including increased time, finances, billing associated with

maintaining practice, increased cost sharing to consumers, and decreased utilization. This indirect impact of the ACA through insurers is a finding that has implications for occupational therapy private practice that may have previously been overlooked. Examples from participants included increased time devoted to fix insurer errors, increased finances due to the need to outsource billing, and increased information tracking and paperwork. Further analysis of these indirect effects needs to be conducted in order to see if this is a trend among other occupational therapy private practices.

An additional point of discussion focuses on the implications to consumers. Because increased cost-sharing and a decrease in utilization was a primary theme found among many of the interviewees, it can be surmised these implications have an impact on consumers. Cost sharing is designed to help consumers make educated choices and decrease unnecessary care by involving their own money into purchasing decisions (Brook et. al., 2006). In addition to increased costs and utilization of services, the impact could be further reaching. This theme could have implications on the health status and functional status of the consumers who are receiving fewer services due to increased costs.

During the 1970s, a similar debate over changes in health care delivery and financing occurred (Brook et. al., 2006). In order to gain greater understanding of the impacts of cost sharing, a study was conducted in 1970 during this time known as the RAND experiment (Brook et. al., 2006). The study showed that participants with higher cost sharing used less health care services and also found that cost sharing did not affect the quality of health care services received because it reduced the use of highly effective and less effective services in nearly the same amounts (Brook et. al., 2006). There are clear parallels that could be made from this study including the theme that participants

have seen cost-sharing increase, and what the potential implications might be. Brook et. al. (2006) also concluded that a reduction in service use during the RAND experiment was mainly the result of participants choosing to not initiate care. If individuals decide to delay care or decline care altogether due to increased cost-sharing, possible health issues could arise. Similar implications for decreased amounts of visits include poorer health, poorer functional outcomes, or longer recovery periods. There is a need to further investigate if this theme is seen on a larger scale.

The study had several limitations. The results could have been strengthened with more participants because this study had only seven. Researchers struggled to determine exact effects of the different settings due to the limited sample size. Also in regard to participants, the results may have been stronger if the sampling was done in a way such that all participants represented similar settings. Researchers interviewed OTs from various practice settings, making it difficult to generalize some of the findings. The seven practices discussed in this study are from the same geographic region in the Mid-Atlantic; therefore the study could have been strengthened if participants from across the United States of America were included. This would be beneficial to see the differing effects of state legislation and/or interpretation and implementation of ACA provisions and Medicare policies on private practice throughout the United States. Due to time constraints, researchers weren't able to continue interviewing until saturation was met. This is another contributing limitation to the present study.

Conclusion

The ACA's provisions and implementation into practice have affected private practice in several different ways. Areas of opportunity as well as areas of concern were noted throughout the course of the present study.

However, based on several participants who indicated a negative impact on their practice, the ACA may indeed have negative implications for the future of occupational therapy in private practice in its current form. In order to remain viable and unique, traditional private practices may need to consider ways to provide more innovative services. Practices which found a niche area within a realm of occupational therapy practice cited that while there are issues, they feel as though their practice is valuable to the healthcare community. The need for advocacy and possibility of a change in practice may yield more positive results within the changing healthcare system. Private practitioners may also need to monitor the ongoing changes in reimbursement and payment structures to maintain or expand their potential for referrals of patients through networks and physicians and the ability to participate in bundled service agreements. As bundled payments become more common, OTs will need to evaluate outcomes and produce evidence to justify services offered in order to maintain roles in rehabilitation.

While there were themes which emerged from the analysis of interviews, the present study examined only the surface of the relationship between the ACA and private practice OT. More research is needed to examine the relationship and gain additional insight about the impact of the bill on practice and long-term viability of private practice.

In discussing further research on the topic of the ACA and private practice OT, it would be valuable to try to include a more diverse group of participants in terms of

location. Another way to change the methodology to include more participants would be to change questions from an interview to a survey. A survey may receive more participants, which could possibly lead to stronger themes from their responses. Another consideration for future research is to include changes in the ACA, which have been implemented since the conclusion of this study. Since the nation's healthcare is constantly changing, researchers must ensure their research is as recent as possible.

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Appendix A

Interview Questions

- 1) Tell me about your experience as an occupational therapy private practitioner.
How did you get to where you are today?
- 2) What is a typical day like running your private practice?
- 3) Can you describe the nature of your services you provide?
- 4) On a scale of 1-10, with 1 being not knowledgeable at all and 10 being very knowledgeable, how knowledgeable do you feel on the topic of the Affordable Care Act in regards to occupational therapy private practice?
- 5) What steps have you taken as a private practitioner to learn about the ACA and its provisions that may affect your practice?
- 6) One of the major goals of the Affordable Care Act is to insure the uninsured and make health care available to everyone. There is a provision that requires most insurance to have “essential health benefits”. This has increased the number of individuals insured and the potential pool of clients. Have you seen an increase in the number of persons seeking your services, and if so, how has this increase affected the accesses to the healthcare that you provide?
- 7) As a provision of the ACA, in 2014 Medicaid expanded healthcare coverage for children ages 6 to 18 by increasing the ceiling in terms of social economic status from 100% Federal Poverty level to 138% FPL. Has this provision impacted your practice, for example, an increase in clients?

- 8) Has your practice experienced any billing or reimbursement changes due to the Affordable Care Act and if so, have these changes affected the time involved to bill and the costs associated with billing?
- 9) The Affordable Care Act has emphasized health care's focus on disease prevention by mandating that private health plans provide coverage for a range of preventative/habilitative services. How has this provision of the Affordable Care act affected your practice? For example, has your practice begun providing preventative/habilitative services, have you been billing for them, has this increased revenues for your practice?
- 10) The ACA has encouraged networking between healthcare facilities. These networks are known as Accountable Care Organizations (ACO). Is your practice currently a part of an ACO, and have you considered joining an ACO network? Why or why not?
- 11) [If yes] Would you recommend a private practitioner to join an ACO?
- 12) With the changes in health care, how do you think private occupational therapy practitioners' roles will change in the future?