Published in final edited form as:
Arch Phys Med Rehabil. 2012 June ; 93(6): 929–934. doi:10.1016/j.apmr.2012.03.014.

Patient Protection and Affordable Care Act: Potential Effects on Physical Medicine and Rehabilitation

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Abstract

The objective was to review pertinent areas of the Patient Protection and Affordable Care Act (PPACA) to determine the PPACA's impact on physical medicine and rehabilitation (PM&R). The law, and related newspaper and magazine articles, was reviewed. The ways in which provisions in the PPACA are being implemented by the Centers for Medicare and Medicaid Services and other government organizations were investigated. Additionally, recent court rulings on the PPACA were analyzed to assess the law's chances of successful implementation. The PPACA contains a variety of reforms that, if implemented, will significantly impact the field of PM&R. Many PPACA reforms change how rehabilitative care is delivered by integrating different levels of care and creating uniform quality metrics to assess quality and efficiency. These quality metrics will ultimately be tied to new, performance-based payment systems. While the law contains ambitious initiatives that may, if unsuccessful or incorrectly implemented, negatively impact PM&R, it also has the potential to greatly improve the quality and efficiency of rehabilitative care. A proactive approach to the changes the PPACA will bring about is essential for the health of the field.

Keywords

Delivery of health care; Health care reform; Patient Protection and Affordable Care Act; Rehabilitation

On march 23rd, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA, also referred to as the ACA)—a law that promises dramatic changes to the way health care is financed and delivered in America. The stated aims of the PPACA are to expand coverage, improve quality, and reduce costs. The law includes a series of reforms to be enacted during the next 2 decades, putting new regulations on insurance policies, altering Medicare and Medicaid, and initiating demonstration projects to improve cost-effectiveness.

The PPACA is sure to affect all fields of medicine, and its impact on physical medicine and rehabilitation (PM&R) may be pronounced. This article describes the components of the PPACA that have the greatest potential to influence medical rehabilitation, and explores what these effects might be. As of the time of this article, there is still much political energy

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No commercial party having a direct financial interest in the results of the research supporting this article has or will confer a benefit on the authors or on any organization with which the authors are associated.

focused on rejecting PPACA all or in part, so there can be no certainty to projected impacts. Also, some of the actions mandated by the PPACA may have unanticipated consequences. Nevertheless, understanding the potential effects should help the field to weather these changes.

COVERAGE EXPANSION

First and foremost, the PPACA alters the landscape of health care by expanding insurance coverage. While the law doesn't achieve universal coverage, it is projected to result in insurance coverage for 32 million previously uninsured Americans.[1] The first way the law achieves this is by expanding Medicaid eligibility to include Americans in a wider income bracket. The PPACA also expands coverage through a series of new regulations limiting insurance exclusions; it outlaws lifetime caps on insurance, makes it illegal to deny coverage because of preexisting conditions (as of 2014), and allows children to remain covered on their parents' plans through age 26. The law also expands insurance access by creating state-run insurance marketplaces, or exchanges, which are to offer consumers a choice of insurance plans.[2] These exchanges should be in place by 2014. Finally, the PPACA expands coverage by establishing 2 different mandates to buy insurance: an employer mandate, and an individual mandate. Businesses with more than 50 employees must provide minimum essential coverage. If a business fails to provide this coverage and any one of their employees receives a tax premium to purchase health insurance, the business will face an annual $2,000 fine per worker. The individual mandate, beginning in 2014, requires almost everyone to have minimum essential coverage or pay a fee annually to the Internal Revenue Service.[3]

Minimum essential coverage, as defined by the law, can have multiple meanings. Relating to the employer mandate, this coverage can be any government plan or any plan offered in the group market within a state. As applied to the individual mandate, it can include any government-sponsored program (Medicare, Medicaid, TRICARE, etc), employer-sponsored programs, any plans offered in the individual market within a state, grandfathered health plans, and "other coverage as recognized by regulation."[4]

This final category of insurance, other coverage, has been the subject of much discussion. Ten categories, among them rehabilitative and habilitative services, are required to be included in this form of minimum essential coverage. The details of how these categories will be addressed, however, have not been officially decided. The Secretary of the U.S. Department of Health and Human Services (HHS) is charged with defining exactly what constitutes minimum essential coverage and establishing regulations by 2014.[5]

The Institute of Medicine (IOM) was commissioned by the HHS secretary to make recommendations by forming an expert committee. The IOM report, published in September 2011, recommended that the essential benefits plan be modeled after a typical small employer plan, modified to include the 10 required categories and to prevent discrimination against patients with certain conditions or disabilities.[6] The committee also stressed the importance of making the plan affordable and prioritizing high-value services of proven effectiveness.[6]

More recently, the Department of HHS announced its intention to allow the states great latitude as to what benchmark programs they may use to establish their state plan.[7] How the rehabilitation and habilitation benefit will be defined is both unknown, and there may be as many definitions as there are state programs.

While the expanded coverage of patients will have dramatic impact on the practice of PM&R, the definition of what constitutes the essential rehabilitation benefit may be of even

greater import. Not only will the new insurance programs depend on this definition, but it is likely that they will shape existing Medicaid benefit programs as well. Thus, the critical question is: what type of rehabilitation services will be considered “essential” in the new insurance? Will coverage be limited to 1 session of physical therapy a year or will unlimited sessions be covered? Both inpatient and outpatient rehabilitation services will be affected by the definitions and subsequent regulations that are promulgated.[8,9]

It is likely that the availability of insurance coverage will increase the use of physician office services by patients. Physiatrists, along with other clinicians, may experience surges in demand for their services that could outstrip capacity, because PM&R is still considered to be a shortage specialty.[10]

ACCOUNTABLE CARE ORGANIZATIONS AND BUNDLING

One of the most anticipated innovations included in the PPACA is the Accountable Care Organization (ACO), a new business model for fee-for-service (FFS) Medicare payment. These organizations, starting officially on January 1, 2012, will be integrated groups of care providers who are held responsible for providing cost-efficient, high quality care.[11] By making improvements in quality, slowing their spending growth, and keeping certain records electronically,[12] ACOs will receive money from the government equal to a percentage (determined by HHS) of estimated money they’ve saved through cost-efficiency. The PPACA includes specific requirements ACOs must meet: they must have at least 5000 Medicare beneficiaries with a strong core of primary care physicians to provide care for them, a legal structure to receive and allocate payments, and a management structure that includes physicians and administrators.

Part of the impetus for the creation of ACOs was to improve health care by creating a vertically integrated business unit that would be responsible for quality throughout an entire course of treatment. The Centers for Medicare and Medicaid Services (CMS) released a list of 33 quality metrics that would be used to judge ACOs and ultimately be linked to ACO payments. While only 1 of these metrics deals with rehabilitation specifically—measuring how well patients function independently—many of the metrics apply generally to all fields of medicine. These include how well patients are able to schedule appointments and receive timely care, how well doctors are able to communicate with patients, and health promotion and education along with shared decision-making between doctors and patients.

Aside from quality assessment, the shift to ACOs will likely accelerate the transition from an FFS system, to one in which larger, vertically integrated, health care organizations, such as Health Maintenance Organizations and ACOs, are responsible for large cohorts of patients. It is hoped that these larger organizations will be able to take advantage of economies of scale and respond to financial incentives that shift from strict utilization management to achieving cost savings while maintaining quality.

One of the obvious problems inherent in the current FFS model is the incentive for overutilization. With the establishment of ACOs, more entities will now exist that can receive bundled payments for entire episodes of care. Thus, ACO incentives will be to limit utilization to that which they believe is minimally necessary in order to retain the excess as profit. For example, 1 proposal suggests bundling the payment for everything needed—services and drugs—to care for patients with end-stage renal disease.[13] Instead of making separate payments for all processes involved—as in the current FFS—1 bundled payment would be made to the provider taking care of the patient. The payment amount would be decided beforehand and would be the average total cost of care.

The field of postacute care (inpatient rehabilitation facilities [IRFs], long-term care hospitals [LTCHs], skilled nursing facilities [SNFs], home health agencies [HHAs], outpatient rehabilitation) has been moving toward bundling payments for more than a decade.[14] Postacute care now takes up over 15% of all Medicare dollars and is one of its fastest growing expenditures.[15] In addition, each category of provider has a separate prospective payment system, making it an ideal target for consolidation in the eyes of policymakers.[16] Medicare has also been funding a contractor, RTI International, to conduct a project entitled the Post Acute Care Payment Reform Demonstration Project.[17] With the Post Acute Care Payment Reform Demonstration Project, RTI International has developed and collected data using a functional assessment tool called the Continuity Assessment Record and Evaluation (CARE) in each postacute setting, except outpatient, as well as in the acute care setting at the time of discharge. It is likely that Medicare will seek to use some version of the CARE tool in its efforts to standardize and calibrate payments across the different post-acute settings.[18]

A 3-year CMS demonstration project launched in 2009, the Acute Care Episode Demonstration Project, has been testing the effectiveness of bundling payments to physicians and hospitals. In this project, CMS is coupling bundled payments with the use of specific quality metrics for 5 different procedures: hip and knee replacements, percutaneous coronary interventions, cardiac defibrillator implants and revisions, coronary artery bypass grafts, and cardiac valve and other major cardiothoracic. Metrics include general measures, such as median length of stay and 30-day readmission rates, but also more specific measures, such as whether surgery patients received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery.[19]

The PPACA requires CMS to initiate a pilot program in 2013 to test the effectiveness and practicality of bundling payments.[20] The HHS is charged with designing the program in which acute and postacute episodes of care for 10 different conditions (to be specified by the HHS) are to be bundled into single payments. The law specifies that quality measures used to assess care should focus on functional status improvement, rates of discharge and readmission, incidence of health care acquired infections, and patient satisfaction.

In addition to quality metrics, bundling also makes it necessary to use case-mix adjustment to make sure bundled payments are fair and accurate. For example, it would be poor practice to charge the same amount for all knee replacements when some patients may have cardiovascular conditions or other complications. Because of bundling, workers in rehabilitation might expect to see an increase in data collection requirements to ensure that reimbursement is appropriate.

Lastly, bundling is likely to impact rehabilitation medicine greatly by changing the way we look at postacute care.[21] By creating separate payment systems for each sector of postacute care in the Balanced Budget Act of 1997, Congress created clear distinctions between the silos of postacute care. Unfortunately, there is increasing fuzziness as to where the boundaries exist between the institutional settings such as an IRF, LTCH, or SNF. Proposals to change regulations, such as the IRF 60% rule, have been used to attempt to shift categories of patients (joint replacement recipients) from 1 setting to another with the assumption that there is a high degree of substitutability of 1 setting for another. In theory, when acute and postacute care episodes are bundled together and the acute care provider is the owner of the bundle, pressures will likely mount to use less expensive postacute settings. Counterbalancing these pressures may be the new economic investment of the bundle owner for the longer-term outcome and health care utilization rates of patients. Rates of rehospitalization may become more carefully scrutinized as a factor in deciding which postacute setting to use.

If there are uniform quality metrics and case-mix adjustment tools adopted, different specialties of medicine and both acute care and postacute care settings will likely be motivated to work in a more unified manner.[17] Bundling, like ACOs, might be seen as a step toward more coordinated and integrated health care. However, this must be balanced by the fact that the assumption that the quality of care is equal for all postacute care sites may not be true for many diagnostic categories.

In the *New England Journal of Medicine,* Kocher and Sahni[22] warned of unforeseen affects of ACOs. In an effort to become ACOs, many hospitals have been hiring physicians at an accelerated rate. Kocher points out that these ACOs may make it harder for physicians in solo or small private practices to remain viable. He adds that, "employment choices that physicians make today [between ACOs and private practices] may not be able to be undone."[22](p1792)

OTHER MEDICARE REFORMS

Beyond ACOs and the prospective bundling of services, there are a number of other reforms to Medicare that are worth mentioning. Prior to the passage of the PPACA, many Medicare-enrolled seniors found themselves having to pay the full cost of their prescription drugs when their annual spending fell into the Medicare Part D donut hole (between $2840 and $4550).[23] Beginning in 2011, Medicare will gradually increase discounts on brand-name medications in this spending range with the goal of covering 75% of medication costs in this range by 2020.

In addition to the other PPACA components, which promote the use of quality metrics and payment-for-performance, the law offers another incentive to measure quality with the use of hospital value-based purchasing. Beginning in 2013, Medicare will give out an estimated total of $850 million to hospitals across America as rewards for meeting a series of quality measures.[24] The funding will come from Medicare savings expected from decreased use of the FFS system, and is expected to increase over time. The metrics used will involve quality of patient care—such as prevention of venous thromboembolism in patients undergoing surgery—and overall ability of hospital staff to communicate with patients.

Another innovation of the PPACA is the proposed creation of the Independent Payment Advisory Board (IPAB). Beginning in 2013, the board will consist of 15 appointed individuals responsible for developing ways of keeping Medicare spending below set limits.[25] The IPAB's suggestions must be implemented, either by Congress or the HHS, unless Congress can come up with ways to achieve equivalent savings.

The IPAB may make no suggestions that would ration health care, raise revenues, raise premiums, share costs, limit benefits to recipients, or change eligibility standards. It also may not lower payments to hospitals or hospices before 2020 or lower payments to clinical laboratories prior to 2016. Therefore, early IPAB suggestions will likely have to take money out of "private Medicare Advantage plans, Medicare's Part D prescription-drug program, or spending on skilled-nursing facilities, home-based health care, dialysis, durable medical equipment, ambulance services, and services of ambulatory surgical centers."[25]

Hospital value-based purchasing is likely to have a significant effect on all health care, including PM&R. While none of the quality metrics used in determining how much money hospitals will receive relate specifically to rehabilitation now, they will require behavioral change for all providers and they are likely to evolve over time. Proposals have already surfaced to expand the program, especially for avoidable readmissions to all postacute sectors.

The IPAB also has the significant potential to affect rehabilitation. As stated earlier, budget cuts in Medicare could take money out of home-based health care and durable medical equipment, both of which could impact rehabilitation. It also may be inevitable that, in the long run, physicians in all fields of medicine will have to live with significant reimbursement cuts to keep Medicare spending within its proscribed limits. The most dramatic current example is the Medicare Sustainable Growth Rate (SGR) method of changing the Medicare Physician Fee Schedule. The Medicare Physician Fee Schedule forms the basis for payment for all outpatient (part B) physician services, and also outpatient rehabilitation therapies. As such, it is of particular importance to rehabilitation practitioners. The SGR was created in 1997 to control Medicare payments to physicians at a time of inflation that was predicted to be experienced for many years to come. More recently, because of the low inflation rates, the formula would have resulted in absolute decreases in reimbursement rates for several years. Each year, however, Congress has passed short-term legislation bypassing the SGR and keeping rates flat or authorizing small percentage increases. At the end of 2011, Medicare was obligated to publish a final rule that would enact about a 27% cut in rates. More recently, Congress extended the prevention of these cuts from taking effect by mandating a 0% fee schedule update through the end of 2012. Depending on how Congress next deals with this challenge, it is likely to be an ongoing threat to the practice of medicine. If physicians or therapists choose to withdraw from Medicare because of its rate structure, Medicare beneficiaries' access to care will be threatened.

While the PPACA does not actually address the SGR, the IPAB will definitely face similar opposition as that mentioned in the preceding paragraph as it attempts to limit Medicare spending. Given the PPACA's language, however, the IPAB may have much more leverage to make its recommendations stick. At the time of this article, legislation that is intended to repeal the IPAB creation is working its way through the House of Representatives.

DEMONSTRATION PROJECTS

The final reforms included in the PPACA are several demonstration projects. Three projects likely to have significant impact on PM&R are Patient-Centered Medical Homes, the Continuing Care Hospital (CCH) Demonstration, and the Independence at Home Demonstration.

Patient-Centered Medical Homes are care models aimed at implementing a more coordinated and proactive approach to primary care.[26] Primary care physicians develop personal relationships with each patient, which includes organizing regular checkups and organizing teams of other medical workers to meet patients' needs. Money is saved by integrating different components of care and by reducing hospitalizations (through regular checkups that prevent health issues before they become a major problem).

Patient-Centered Medical Homes are still in development, however, and there is a general consensus that they need to focus more on high-need populations. In the past, this has meant those with chronic health conditions, because this group requires more services.[27] However, there is a growing realization that individuals with disabilities should specifically be targeted for inclusion in this program given that they usually have multiple chronic conditions that are compounded by functional limitations.[27,28]

Another demonstration project included in the law, the CCH, proposes to create a new delivery model and to bundle payments for its services.[29] Rather than bundling together aspects of acute and postacute care, the CCH is intended to offer the services presently provided by LTCHs, inpatient rehabilitation hospitals (IRHs), and hospital-based SNFs.[30] IRHs could become CCHs by widening their range of services, or partnering with the other

organizations mentioned above to form a virtual CCH. CCHs are to be paid for, and held accountable for, the entire length of a patient's postacute care episode, plus the 30 days immediately after discharge. The prospective payment is intended to be based on a patient classification system for CCH care groups.

One final demonstration project with the potential to have a significant impact on the field of rehabilitation is the Independence at Home Demonstration program. The Independence at Home Demonstration, which began in December 2011, is an initiative to provide home health care to chronically ill patients.[31] Participating organizations provide home visits to 200 or more eligible patients with teams led by physicians, nurse practitioners, or physicians assistants with certain qualifications.[32] If organizations meet the requirements of the Independence at Home Demonstration and also achieve cost savings by avoiding hospitalizations and emergency department visits, they can receive financial incentives from the CMS.

The program is directed specifically at Medicare beneficiaries with chronic conditions, a group that is likely to require physiatrists and other rehabilitation workers. Patients participating in the demonstration are required to have "received acute or sub-acute rehabilitation services within the past twelve months" and "require assistance of another person … for two or more activities of daily living."[32](p6) Therefore, although the Independence at Home Demonstration is centered on providing primary care, the participation of physical therapists and other rehabilitation clinicians will definitely be required for it to succeed. Rehabilitation clinicians participating in the program will need to adapt to providing their services in a home setting and become familiar with different aspects of home care.[33] If the Independence at Home Demonstration proves effective, the practice of home health care may become more widely used in all fields of medicine, including rehabilitation.[33]

QUALITY METRICS

Numerous components of the law encourage the use of quality metrics, including ACOs, Hospital Value Based Purchasing, and bundled payments. Other initiatives exist to link payments to quality reporting in LTCHs, IRHs, hospice programs, and cancer hospitals exempt from prospective payment systems.[20] Beginning in 2014, LTCHs and IRHs that fail to report yearly quality measures will receive 2% reductions in payment rates for discharges during those years— even if this means a decrease in payment amount from the previous year. The CMS has already published the 2 required quality metrics for IRFs, catheter-associated urinary tract infections and new or worsening pressure ulcers.[34] Similar payment reductions are applied to hospice programs, which would receive a 2% decrease in market basket percentage increases under the same conditions. Cancer hospitals do not risk penalization, but are still required to report HHS-mandated quality metrics beginning in 2014. The CMS is required to make the data collected from all 4 of these organizations available to the public.

PPACA IN A LEGAL AND POLITICAL CONTEXT

Because the PPACA does not exist in a vacuum, it's necessary to look at the law in a political context. The Republican party has pledged to repeal and replace the PPACA and what follows is an analysis of if, and how, this goal could be achieved.

No part of the PPACA is immune to repeal, but Republicans' chances of successfully nullifying the law are almost nonexistent without a Republican president and a majority in both branches of Congress.[35,36] Additionally, pushing for repeal may become less popular politically; reversing the PPACA would prevent insurance expansion to 32 million

Americans, loosen regulations in the insurance industry, and effectively eliminate many initiatives aimed at keeping Medicare spending in check.[20,36] The Republican party has pledged to create a feasible alternative to the PPACA, but turning this alternative into a second reform law would reignite a congressional health care debate that Americans may not want to see again.[37]

Aside from a sweeping repeal of the entire PPACA, Republicans can undertake (and already are undertaking) strategies to nullify specific sections of the bill, or make them as difficult to implement as possible. While some Republican governors support the creation of state-based insurance exchanges, others are refusing to establish them.[38] This tactic could delay exchange creation. Additionally, the IPAB is a target for defunding by Republicans in Congress.[25]

The largest threat to the PPACA comes from the potential unconstitutionality of its individual mandate to buy insurance. Congress justifies the mandate under the commerce clause of the Constitution, which states that the government can "regulate commerce … among the several states," but opponents of the law argue that it extends the commerce clause to unprecedented and illegitimate levels.[39] Many district and appeals courts have ruled on the constitutionality of the commerce clause; in the majority of cases, it has been ruled constitutional.

On November 14, 2011, the Supreme Court agreed to hear appeals from the *State of Florida v HHS* to decide whether or not the individual mandate to buy insurance is constitutional, and if not, whether the mandate can be repealed without retracting the rest of the law.[40,41] The penalty included in the mandate may also be classified as a tax, which would postpone the decision on its constitutionality until the first American pays the tax in 2015. Also discussed will be whether it is constitutional for the federal government to mandate that states expand Medicaid and pay for newly covered individuals.[42,43] Oral arguments were presented in March 2012, and the court may announce a decision by June 2012.

The 2 events that will play the largest parts in determining the durability of the PPACA are yet to come: the 2012 presidential election and the Supreme Court ruling on the individual insurance mandate. A Republican president, along with a Republican majority in Congress, would put the law in significant jeopardy. Likewise, a ruling from the Supreme Court that the law is unconstitutional could mean its immediate nullification. Neither of these events can be predicted, however, so only time will tell if the PPACA is here to stay.

CONCLUSIONS

The PPACA has significant implications for the field of PM&R. The heart of the law expands coverage, consistency within care-providing structures, and accountable, cost-efficient, high quality care. There will be pressure on PM&R to develop uniform standards across the postacute care continuum, to cope with providing services to 32 million more insured lives, and to report numerous quality metrics. There is no doubt that in the coming years workers in rehabilitation will face challenges and changes to the norm. It remains to be seen if these changes will allow more complete access to medical rehabilitation services for all Americans, or if cost constraints result in greater limitations in access.

List of Abbreviations

ACO	Accountable Care Organization
CARE	Continuity Assessment Record and Evaluation

CCH	Continuing Care Hospital
CMS	Centers for Medicare and Medicaid Services
FFS	fee-for-service
HHA	home health agency
HHS	Department of Health and Human Services
IOM	Institute of Medicine
IPAB	Independent Payment Advisory Board
IRF	inpatient rehabilitation facility
IRH	inpatient rehabilitation hospital
LTCH	long-term care hospital
PM&R	physical medicine and rehabilitation
PPACA	Patient Protection and Affordable Care Act
SGR	Medicare Sustainable Growth Rate
SNF	skilled nursing facility

References

1. Jackson, J.; Nolen, J. [Accessed July 28, 2011.] Health care reform bill summary: a look at what's in the bill. CBS News [serial online]. 2010. Available at: http://www.cbsnews.com/8301-503544_162-20000846-503544.html
2. Explaining health care reform: what are health insurance exchanges?. Washington (DC): The Henry J. Kaiser Family Foundation; 2009. Report No 7908
3. Democratic Policy & Communications Center; 2010. Affordable Care Act: section-by-section analysis with changes made by title X. Available at: http://dpc.senate.gov/healthreformbill/healthbill96.pdf
4. Bianchi, AJ. The "employer responsibilities" requirement of the Patient Protection and Affordable Care Act: a view from the weeds. Boston: Mintz Levin; 2010. Available at: http://www.mintz.com/newsletter/2010/Advisories/0321-0410-NAT-HCR/web.html
5. Pezzoni, A. Health care reform timeline. San Jose: McCahan, Helfrick, Thiercof & Butera Accountancy Corp; 2010. Available at: http://www.mhtb.com/wordpress/?p=21
6. Summary of key themes in IOM report on "essential health benefits: balancing coverage and cost" from a disability and rehabilitation research perspective. Washington (DC): Disability and Rehabilitation Research Coalition; 2011. Report
7. Affordable Insurance Exchanges: Choices, Competition and Clout for States. Washington (DC): U.S. Department of Health and Human Services; 2012. [updated April 5, 2012; cited 2012 April 5]. Available at: http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html
8. Chan L, Doctor J, Temkin N, et al. Discharge disposition from acute care after traumatic brain injury: the effect of insurance type. Arch Phys Med Rehabil. 2001; 82:1151–4. [PubMed: 11552183]
9. Ingram, C. Presentation. The intersection of essential health benefits and Medicaid: hearing before the IOM Committee on the Determination of Essential Health Benefits. Hamilton (NJ): Center for Health Care Strategies, Inc; 2011.
10. Hogan PF, Dobson A, Haynie B, et al. Physical medicine and rehabilitation workforce study: the supply of and demand for physiatrists. Arch Phys Med Rehabil. 1996; 77:95–9. [PubMed: 8554483]
11. Fisher ES, Shortell SM. Accountable care organizations: accountable for what, to whom, and how. JAMA. 2010; 304:1715–6. [PubMed: 20959584]

12. Lowes, R. [Accessed April 5, 2012.] Proposed Rules for ACOs Push EHR Adoption. Medscape Medical News. 2011. Available at: http://www.medscape.com/viewarticle/740055
13. Bundled Payment AHA Research Synthesis Report. Chicago: American Hospital Association Committee on Research; 2010 May. p. 8Report
14. Chan L. The state-of-the-science: challenges in designing post-acute care payment policy. Arch Phys Med Rehabil. 2007; 88:1522–5. [PubMed: 17964899]
15. Health care spending and the Medicare program. Washington (DC): MedPAC; 2011.
16. Hackbarth, GM.; Crosson, FJ.; Miller, ME. Report to Congress: Medicare Payment Policy. Washington (DC): MedPAC; 2010.
17. Gage, B.; Smith, L.; Morley, M., et al. Post-Acute Care Payment Reform Demonstration Report to Congress Supplement—Interim Report. Centers for Medicare & Medicaid Services; Baltimore: 2011. Report No 0209853.005.001
18. RTI International. [Accessed November 21, 2011.] Overview of the Medicare post acute care payment reform initiative. Available at: https://www.cms.gov/DemoProjectsEvalRpts/downloads/PACPR_RTI_CMS_PAC_PRD_Overview.pdf
19. Anticipated ACE demonstration quality monitoring measures: frequency of reporting by surgical procedure. Baltimore: Center for Medicare and Medicaid Services; 2009.
20. United States. Congress. House. Compilation of Patient Protection and Affordable Care Act: as amended through November 1, 2010 including Patient Protection and Affordable Care Act health-related portions of the Health Care and Education Reconciliation Act of 2010. Washington (DC): U.S. Government Printing Office; 2010. p. xxiii
21. DeJong G. Bundling acute and postacute payment: from a culture of compliance to a culture of innovation and best practice. Phys Ther. 2010; 90:658–62. [PubMed: 20435610]
22. Kocher R, Sahni NR. Hospitals' race to employ physicians–the logic behind a money-losing proposition. N Engl J Med. 2011; 364:1790–3. [PubMed: 21449774]
23. Bihari, M. [Accessed July 21, 2011.] Understanding the Medicare part D donut hole. About.com. Available at: http://healthinsurance.about.com/od/medicare/a/understanding_part_d.htm
24. U.S. Department of Health & Human Services. [Accessed April 29, 2011.] Administration Implements Affordable Care Act Provision to improve care, lower costs. Available at: http://www.hhs.gov/news/press/2011pres/04/20110429a.html
25. Aaron HJ. The Independent Payment Advisory Board--Congress's "good deed. N Engl J Med. 2011; 364:2377–9. [PubMed: 21561342]
26. Harper, MA.; Balara, JE. Patient Centered Medical Home: an approach for the health plan. Indianapolis: HTMS; 2009.
27. Gulley SP, Rasch EK, Chan L. If we build it, who will come? Working-age adults with chronic health care needs and the medical home. Med Care. 2011; 49:149–55. [PubMed: 21206295]
28. Gulley SP, Rasch EK, Chan L. The complex web of health: relationships among chronic conditions, disability, and health services. Public Health Rep. 2011; 126:495–507. [PubMed: 21800744]
29. Questions and answers for the Continuing Care Hospital (CCH) concept. Association AMRP; 2009.
30. Gans, BM. Ensuring the survival of the rehabilitation field in the era of health care reform. Focus on Rehabilitation. West Orange (NJ): Kessler Institute for Rehabilitation; Summer. 2011 p. 6
31. Independence at Home Demonstration. Washington (DC): Department of Health and Human Services, Centers for Medicare and Medicaid Studies; 2011. Report
32. Services CfMaM. Independence at Home (IAH) Frequently Asked Questions for Applicants. 2011.
33. Landers SH. Why health care is going home. N Engl J Med. 2010; 363:1690–1. [PubMed: 20961239]
34. Medicare program; inpatient rehabilitation facility prospective payment system for federal fiscal year 2012; changes in size and square footage of inpatient rehabilitation units and inpatient psychiatric units. Final rule. Fed Regist. 2011; 76:47836–915. [PubMed: 21818878]

35. Hornick, E. [Accessed August 12, 2011.] Reality check: repealing health care reform. CNN [serial online]. Available at: http://articles.cnn.com/2011-01-18/politics/health.care.debate.ahead_1_health-care-reform-repeal-house-republicans?_s=PM:POLITICS
36. Oberlander J. Beyond repeal–the future of health care reform. N Engl J Med. 2010; 363:2277–9. [PubMed: 21083378]
37. GOP.gov. [Accessed August 12, 2011.] Repeal and replace the job-destroying health care law. Available at: http://www.gop.gov/pledge/healthcare
38. Appleby, J. [Accessed March 30, 2012.] Health insurance exchange 101. PBS. Available at: http://www.pbs.org/newshour/rundown/2011/08/health-insurance-exchange-101-1.html
39. Heiring, PW. Consitutional challenges asserted in health care reform litigation. Faegre & Benson; Apr 13. 2011 Available at: http://www.faegre.com/13127
40. Vaida, B.; Eisenhowever, K. [Accessed November 21, 2011.] Scoreboard:tracking health law court challenges. Kaiser Health News. Nov 14. 2011 Available at: http://www.kaiserhealthnews.org/Stories/2011/March/02/health-reform-law-court-case-status.aspx#florida
41. Mears, B. [Accessed November 21, 2011.] Supreme Court takes up challenge to health care reform law. CNN. Nov 14. 2011 Available at: http://articles.cnn.com/2011-11-14/politics/politics_health-care_1_oral-arguments-health-care-reform-law-affordable-care-act?_s=PM:POLITICS
42. Business Management Daily. [Accessed March 30, 2012.] Supreme Court to decide: is health care reform law constitutional?. Nov 21. 2011 Available at: http://www.businessmanagementdaily.com/28862/supreme-court-to-decide-is-health-care-reform-law-constitutional
43. de Vogue, A. ABC News; Supreme Court to rule this spring on health care law. November 14, 2011Available at: http://abcnews.go.com/blogs/politics/2011/11/supreme-court-will-rule-this-year-on-health-reform-law/