Mandated report: Improving Medicare's payment system for outpatient therapy services

Adaeze Akamigbo and Ariel Winter

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Mandated report due June 15, 2013

- Middle Class Tax Relief and Job Creation Act of 2012
  - Requires recommendations on how to reform the payment system under Part B to reflect patients' acuity, condition and therapy needs
  - Examine private sector initiatives to manage outpatient therapy benefits

Today's presentation

- Analytical approach to address the mandate
- Background on therapy services
- Spending and use of outpatient therapy services in Medicare
- Therapy caps and exceptions process
- Policy options to consider to reform outpatient therapy benefit
  - Improve management of the benefit
  - Collect data on functional status
  - Reform the therapy payment system

Approach to analysis

- Literature review
- Medicare claims data analysis
- Meetings with rehabilitation professional societies
- Hosted panel of rehabilitation researchers and practitioners
- Conducted interviews with health plans and benefit managers

What is outpatient therapy?

Physical therapy: Improve and restore function after disease or injury (e.g., lift objects)

Occupational therapy: Improve and restore the ability to independently conduct activities of daily living (e.g., bathing) and instrumental activities of daily living (e.g., food preparation)

Speech-language pathology: Assist patients with communication and swallowing

Conditions for outpatient therapy services to be furnished

- Need for therapy services
- A diagnosis, treatment plan, and therapy goals in the medical record
- Care of a physician or non-physician practitioner
- Payments are based on physician fee-schedule, and are the same across all sites of care

Providers of outpatient therapy services

- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Physicians
- Qualified physical and occupational assistants are covered but must be supervised

Where outpatient therapy services are delivered

- Private practices
  - Physical therapists, occupational therapists, speech-language pathologists, non-physician practitioners, physicians
- Outpatient facilities
  - Nursing facilities, hospital outpatient departments (HOPDs), outpatient rehab facilities, comprehensive outpatient rehab facilities, home health agencies

Therapy caps

- Annual per-beneficiary limit on outpatient therapy services (caps)
  - Cap for PT and SLP services combined: $1,880
  - Cap for occupational therapy services: $1,880
  - Services obtained from HOPDs will be subject to caps from October to December 2012
- Spending above $3,700 for PT/SLP and occupational therapy will trigger manual medical review (Oct. to Dec. 2012)

Exceptions to therapy caps

- The exceptions process allows beneficiaries to receive services above the cap limits (required by statute)
- KX modifier is placed on the claim for services delivered beyond cap limits
- Caps exceptions expire on December 31, 2012

Outpatient therapy: Spending and use in 2011

	Number of therapy users (millions)	Total spending (billions)	Share of spending	Mean spending per user	Mean visits per user
Physical Therapy	4.3	$ 4.1	71%	$ 942	13
Occupational Therapy	1.1	1.1	19	1,026	14
Speech-Language Pathology	0.6	0.5	10	981	12
Total	**4.9**	**$ 5.7**		**$ 1,173**	**16**

Source: MedPAC analysis of 2011 Medicare claims data.
Note: Totals reflect unique individuals while per-user service counts include beneficiaries who use multiple therapy types. Numbers are preliminary and subject to change.

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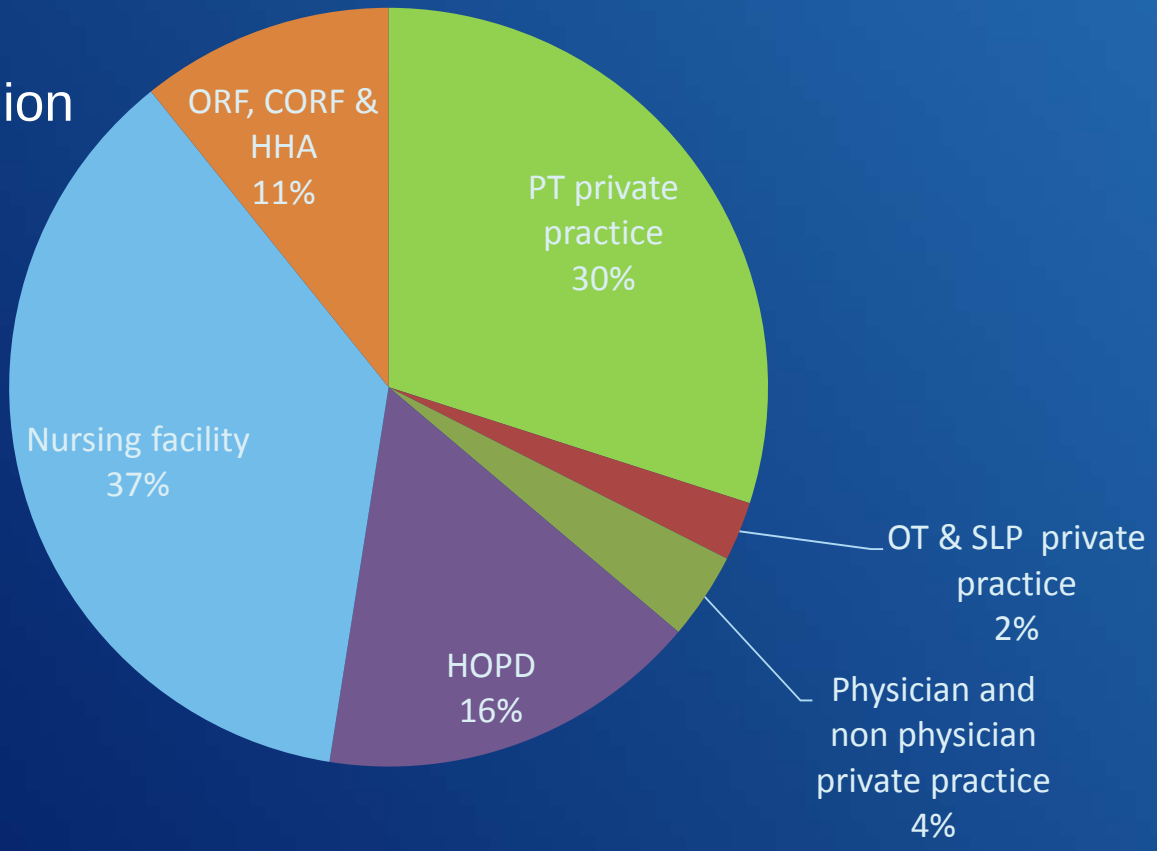
Distribution of spending on outpatient therapy by setting, 2011

Total = $5.7 billion



ORF (outpatient rehabilitation facilities); CORF (comprehensive outpatient rehabilitation facilities) ; HHA (home health agencies); HOPD (hospital outpatient departments); PT (physical therapy); OT (occupational therapy); SLP (speech-language pathology). Numbers are preliminary and subject to change. Numbers are preliminary and subject to change.

Source: MedPAC analysis of 100% Medicare claims data.

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Average growth in spending on outpatient therapy services

Setting	2004 (billions)	2009 (billions)	2011 (billions)	Average annual % change 2004-2009	Average annual % change 2009-2011
Facilities					
Nursing facilities	$ 1.2	$ 1.9	$ 2.1	**8%**	**7%**
Subtotal, all facilities	2.8	3.3	3.7	3	4
Private practices					
Physical therapists' private practice	1.0	1.5	1.7	**10%**	5%
Subtotal, all private practices	1.4	1.7	2.1	6	4
Total, all settings	$ 4.3	$ 5.3	$ 5.7	4%	**4%**

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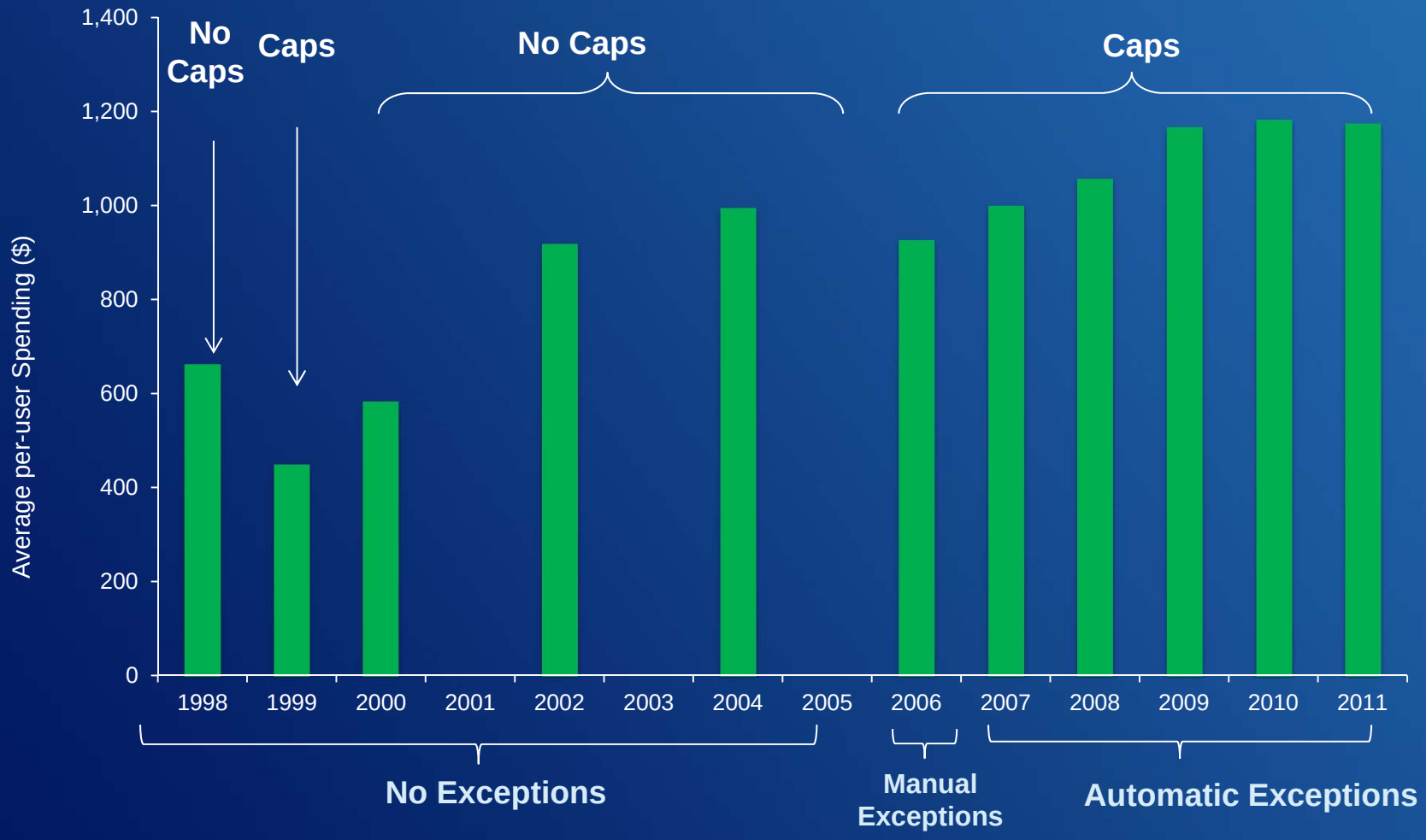
Note: Numbers may not sum to totals due to rounding. Numbers are preliminary and subject to change.
Source: MedPAC analysis of 2011 Medicare claims data.

Per-user spending on outpatient therapy,1998-2011



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Source: MedPAC analysis of Medicare claims data and CSC reports. Data not available for 2001, 2003, & 2005.
Note: Numbers are preliminary and subject to change.

Total Medicare spending on outpatient therapy, 1998-2011

Source: MedPAC analysis of Medicare claims data and CSC reports. Data not available for 2005.
Note: Numbers are preliminary and subject to change.

Spending per therapy user in high and low spending counties (national mean 2011 = $1,173)

High-spending counties

Rank	State	County	$
1	LA	ST. MARY	3,582
2	TX	JIM WELLS	3,293
3	LA	AVOYELLES	2,799
4	NY	KINGS	2,798
5	TX	RUSK	2,696
6	PA	LAWRENCE	2,653
7	TX	SAN PATRICIO	2,609
8	MS	LINCOLN	2,581
9	TX	HARDIN	2,550
10	LA	LINCOLN	2,501

Low-spending counties

Rank	State	County	$
1	NY	OTSEGO	406
2	IA	CLAY	428
3	MN	OLMSTED	436
4	ID	BLAINE	454
5	WI	JUNEAU	481
6	MN	MARTIN	506
7	AZ	APACHE	512
8	MT	YELLOWSTONE	513
9	ND	GRAND FORKS	517
10	MN	CASS	521

MEDPAC Source: MedPAC analysis of 2011 Medicare claims data
Numbers are preliminary and subject to change.

A large number of therapy users exceeded caps due to exceptions

Beneficiaries who exceeded 2011 caps ($1,870)

	Physical therapy/Speech-language pathology cap	Occupational therapy cap
Share who exceeded caps	19%	22%
Mean spending among those who exceeded caps	$3,013	$3,026
Mean spending among those who did not exceed caps	$542	$475

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Source: MedPAC analysis of 2011 Medicare claims data
Numbers are preliminary and subject to change.

Lack of detailed diagnosis codes

- Few meaningful codes to determine patient acuity
- Most are non-specific diagnosis codes
- Top code is a V-code which is descriptive of the service provided but not the condition

	ICD-9	Definition	Share of total therapy payments
1	V57.1	Non-Specific, Other physical therapy	8%
2	724.2	Low back pain	5%
3	781.2	Abnormality of gait	4%
4	719.7	Difficulty in walking	3%
5	728.87	Generalized muscle weakness	3%

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Source: MedPAC analysis of 2011 Medicare claims data
Numbers are preliminary and subject to change.

CMS lacks data on functional outcomes

- No widely-used standardized tools to measure functional status in outpatient therapy
- Many tools are discipline-specific, and are proprietary
- Providers are not required to report standardized data on functional status to be reimbursed

Policy options the Commission may consider

Improve Medicare's ability to manage the benefit	Short-term
Develop a standardized instrument to collect data on functional status	Long-term
Reform the payment system for outpatient therapy services *Alternative 1*: Episode-based payments *Alternative 2*: Private sector approach	

Options to improve management of the benefit

- Permanently include services from HOPDs under therapy caps
- Focused reviews in high-use geographic areas and for aberrant providers using new Secretarial authority
- Reduce certification period from 90 days to 45 days
- Eliminate use of V-codes
- Give Secretary authority to adjust cost sharing for outpatient therapy services

Collect information on functional status using standardized instrument

- Facilitates classification of patients based on complexity, severity, and therapy needs for reporting to CMS
- Instrument would reflect demographic, diagnosis, surgery, affected body structures, medications, limitations with activities of daily living
- A pre-requisite step to building a bundled payment system

Change payment system: Alternative one

Design an episode-based payment system

- Prospectively determine the resource needs of a majority of therapy users
- Using the data collected using the standardized tool to create payment categories
- Use standardized tool to classify patients into payment groups
- Outlier policy for high-use and low-volume episode

Change payment system: Alternative two

Adopt private sector approach

- Similar to private plans, implement a per-beneficiary limit on the number of therapy visits
- Require prior authorization for additional visits

Discussion

Policy options

- Improve Medicare's ability to manage the benefit
- Develop a standardized instrument to collect data on functional status
- Reform the payment system for outpatient therapy services
  - *Alternative 1*: Episode-based payments
  - *Alternative 2*: Private sector approach