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

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November 1, 2012

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Mandated report: Improving outpatient therapy services

- 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
  - Due June 15, 2013

Framework to evaluate potential policy changes

- How does the recommendation impact Medicare program spending?
- Will it improve beneficiary access to care?
- Will it improve the quality of care Medicare beneficiaries receive?
- Will the recommendation advance payment reform? Does it move away from fee-for-service and encourage a more integrated delivery system?

Today's presentation

- Commissioner questions
  - Demographic characteristics of beneficiaries who exceed caps
  - Site of care for high- and low-spenders on therapy distribution
  - Share of beneficiaries who exceeded caps among top spending areas
  - Advance beneficiary notice for noncoverage
- Draft recommendations to reform outpatient therapy benefit

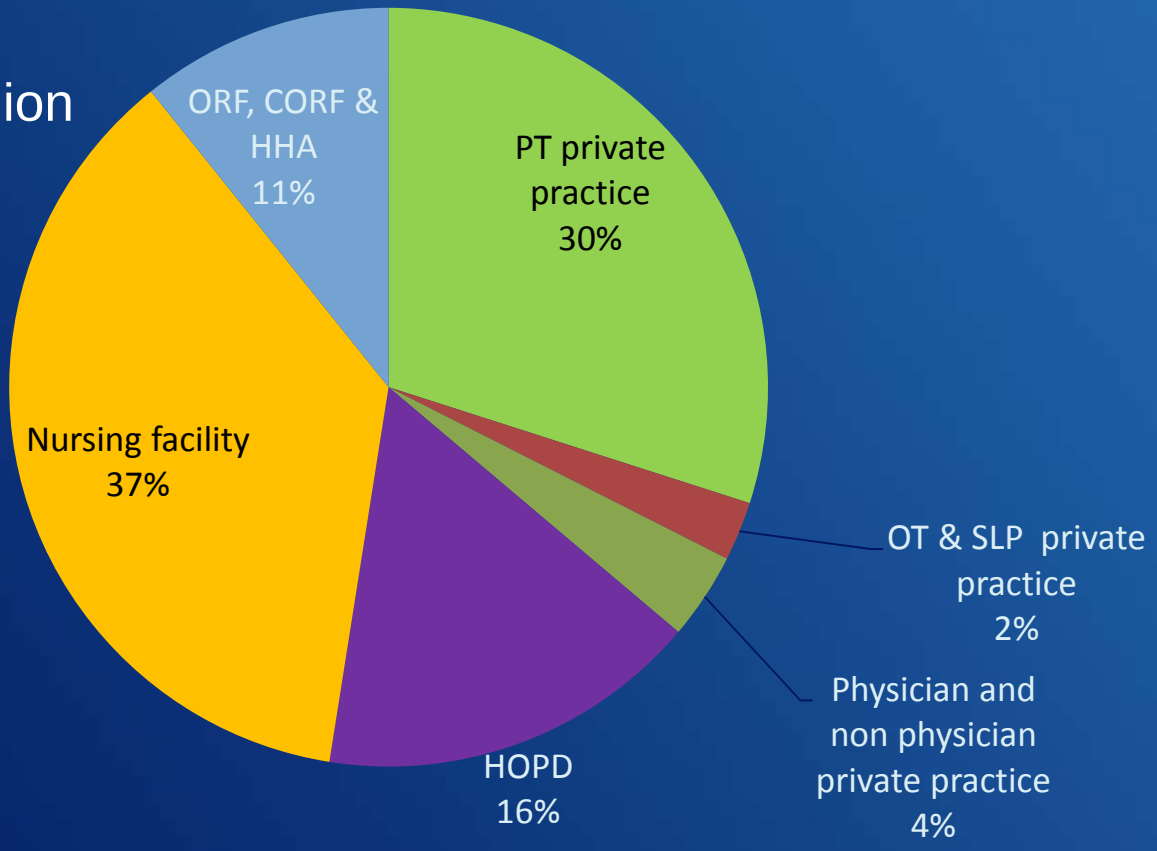
Demographic characteristics of beneficiaries who exceed caps

	All PT/SLP users N = 4.5 million	PT/SLP users above cap 19%	All Occupational Therapy users N = 1.0 million	OT users above cap 22%
Mean age (years):	72.9	75.3	76.2	78.3
86 years and older	14%	20%	26%	32%
African American	8	9	10	12
Women	64	65	67	68
Dual-eligibles	27	37	47	62

MEDPAC Source: MedPAC analysis of 100% Medicare claims data from 2011.

Distribution of spending on outpatient therapy by setting, 2011

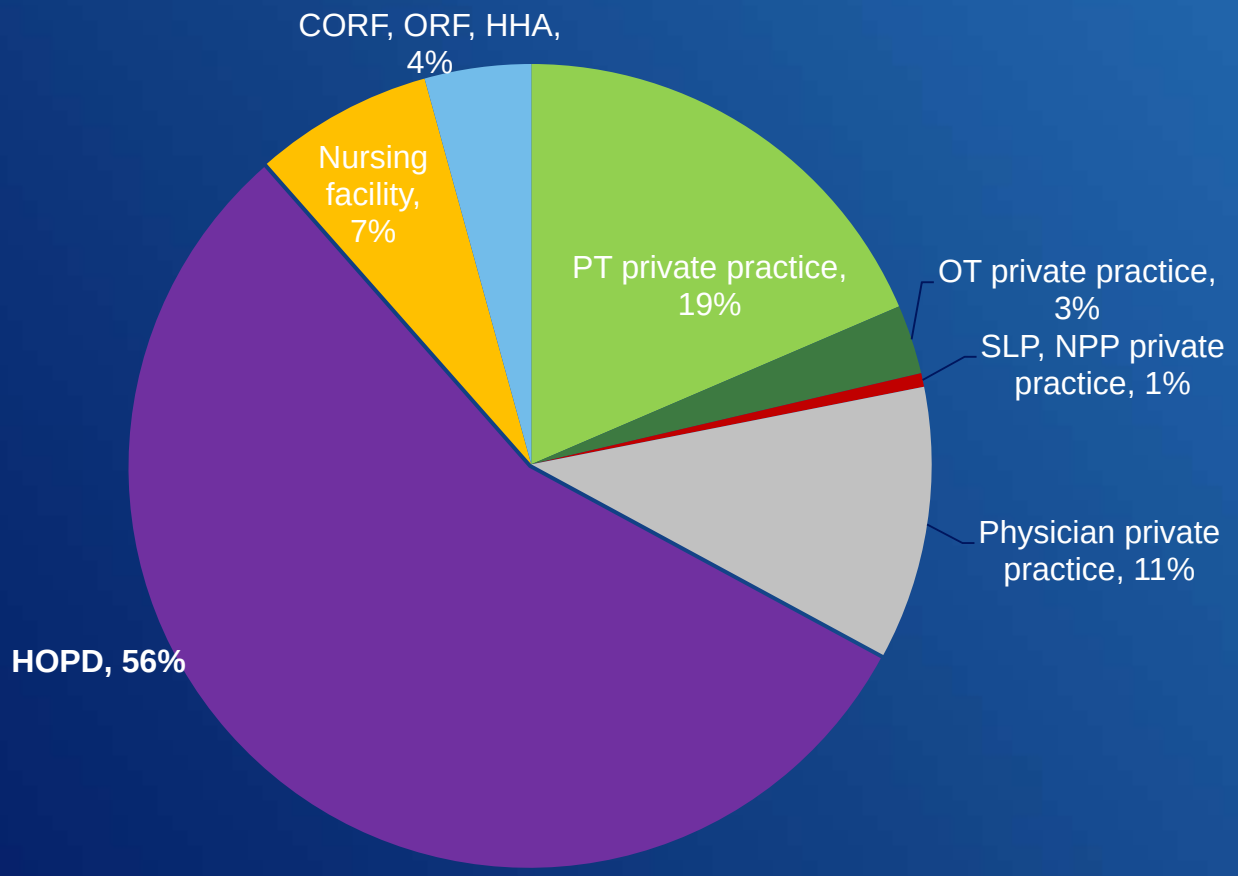
Total = $5.7 billion



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)

Source: MedPAC analysis of 100% Medicare claims data.

Site of care for lowest spending beneficiaries (bottom 10%), 2011



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); NPP (non-physician practitioner).

Source: MedPAC analysis of 100% Medicare claims data.

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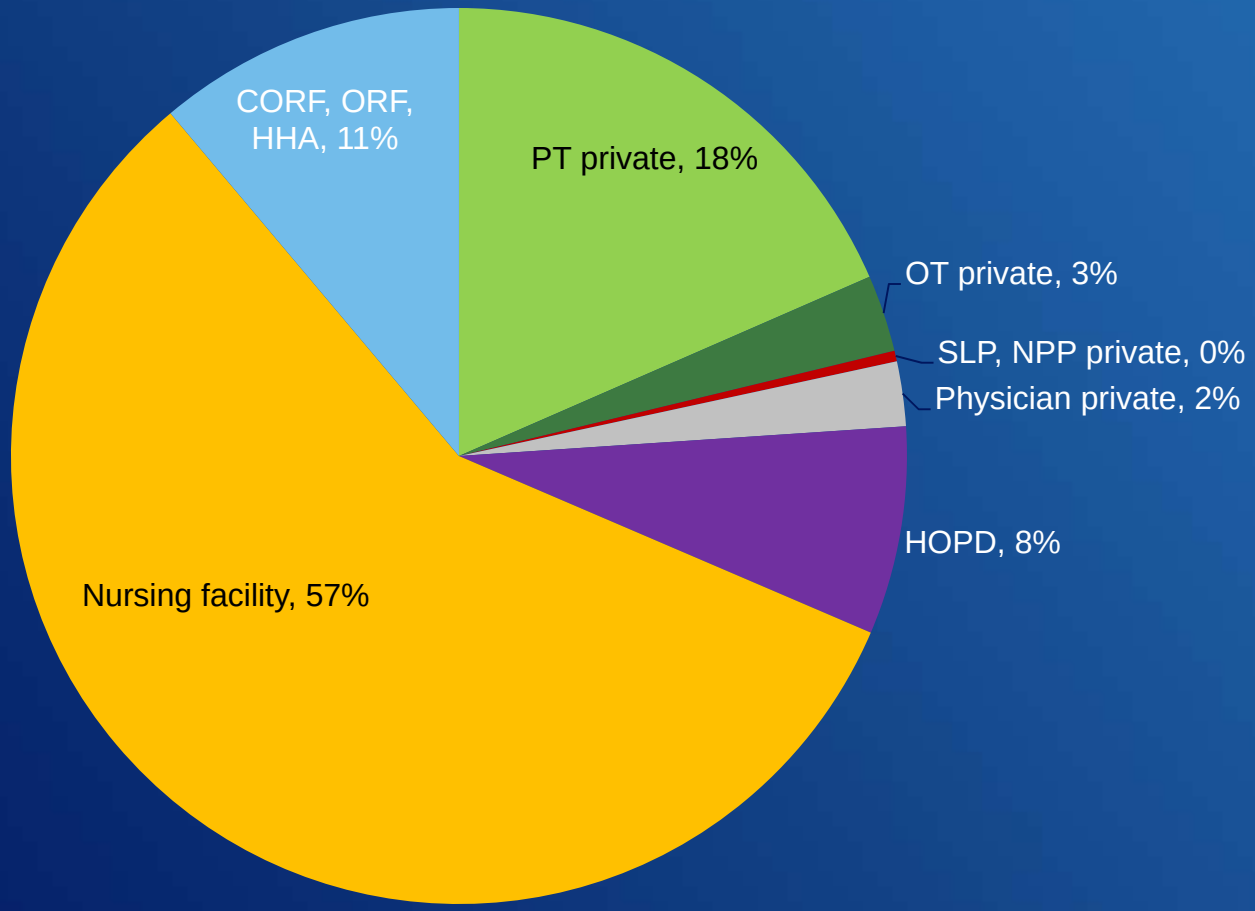
Site of care for highest spending beneficiaries (top 10%), 2011



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); NPP (non-physician practitioner).
Source: MedPAC analysis of 100% Medicare claims data.

Share of beneficiaries who exceeded either cap in the top 10 counties, 2011

State	County	Mean per-user spending	Percent who exceeded either cap
LA	ST. MARY	$3,582	32%
TX	JIM WELLS	3,293	34
LA	AVOYELLES	2,799	37
NY	KINGS	2,798	39
TX	RUSK	2,696	31
PA	LAWRENCE	2,653	36
TX	SAN PATRICIO	2,609	32
MS	LINCOLN	2,581	28
TX	HARDIN	2,550	26
LA	LINCOLN	2,501	32
Share of beneficiaries who exceeded either cap			19%

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Note: Mean per-user spending reflects program spending, 80% of total allowed amounts.
Source: MedPAC analysis of 100% Medicare claims data.

CMS's policy on issuing Advance Beneficiary Notice for outpatient therapy

- ABNs inform beneficiaries that services may not be covered if medically unnecessary
- CMS encourages—but does not require—providers to issue ABNs routinely for therapy services
- Providers must issue an ABN for the beneficiary to be held liable for services that are not deemed medically reasonable and necessary

Concerns about current law

- Exceptions process sunsets at the end of 2012
  - Hard caps in place January 2013
- Caps without exceptions may impede access to necessary treatment
- With appropriate clinical judgment, outpatient therapy can restore function, and allow beneficiaries to live independently

Concerns about the outpatient therapy benefit under Medicare

- Provision of therapy services is sensitive to payment policy
- Regional variation not explained by health status
- CMS lacks basic information
  - Who should get therapy services?
  - What type, and for how long?
  - Do they improve, and by how much?

Current process for manual medical reviews at $3,700 threshold

- CMS
  - Accepts requests by mail or fax only
  - Contractors do not always acknowledge receipt of requests
- Providers
  - Do not always include pertinent information such as beneficiary names, NPI of providers, reason for request to exceed $3,700 threshold

Manual medical reviews—*streamlined*

- Congress would need to allocate resources in legislation for CMS to perform medical manual reviews in a timely manner
- Process to accept requests electronically, in addition to mail or fax
- Providers should receive immediate confirmation that requests have been received
- Reviews should be completed—acceptance or denials—within 10 business days
- Within the 10-day time frame, allow two visits; the therapist bears financial responsibility
- Consider one or two MACs to conduct all manual medical reviews nationwide for consistency in the review process