



Advising the Congress on Medicare issues

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

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November 1, 2012

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?

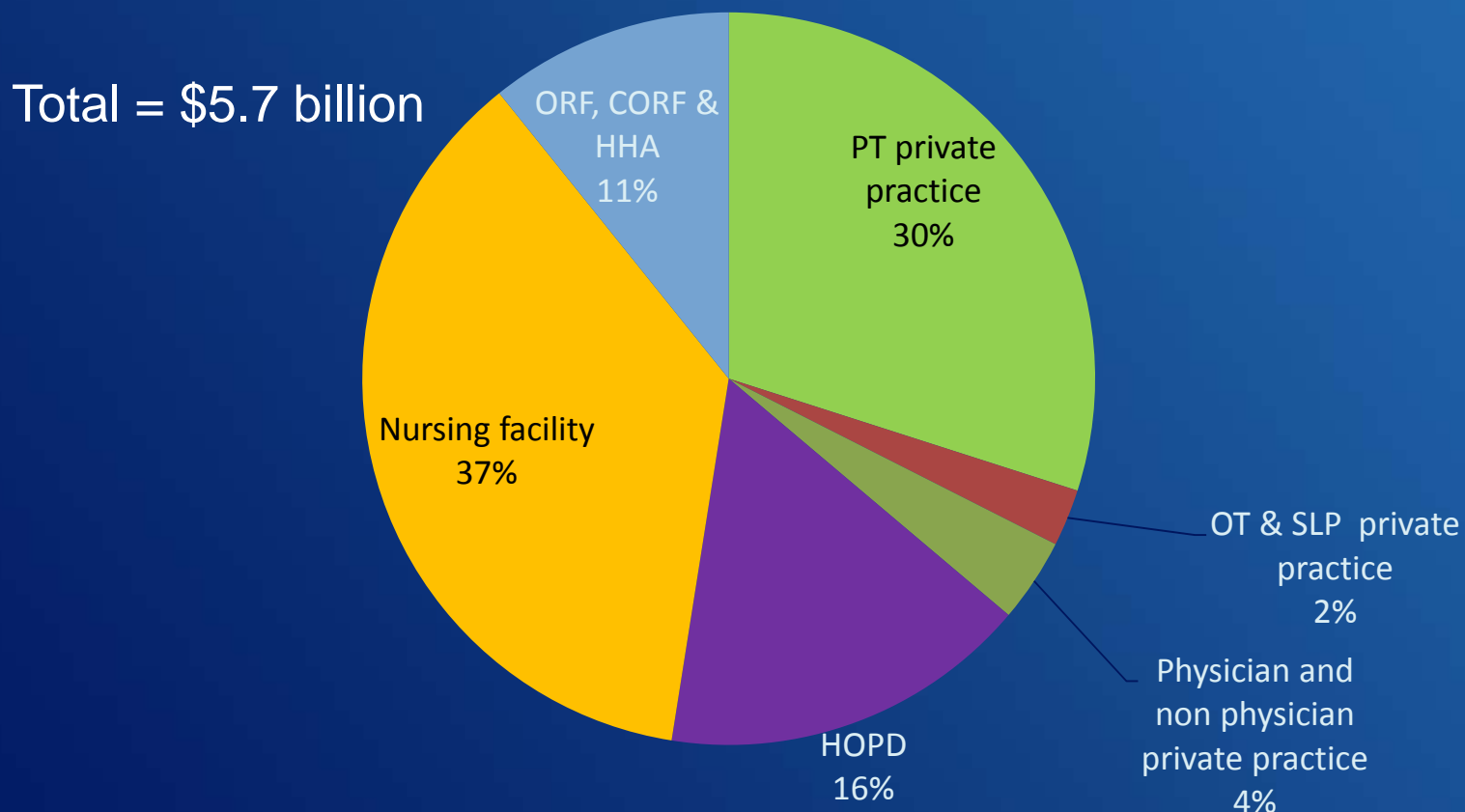
Today's presentation

- 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 |

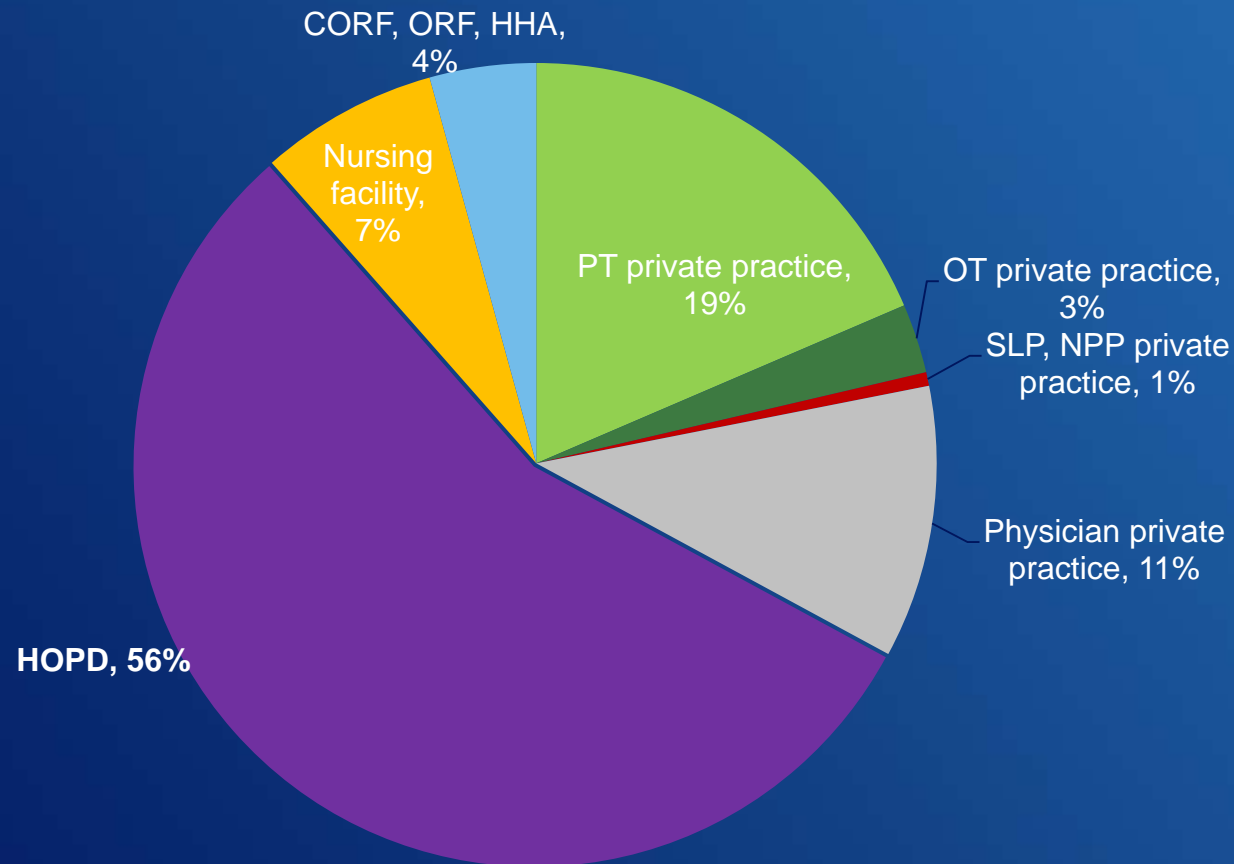
Distribution of spending on outpatient therapy by setting, 2011



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)

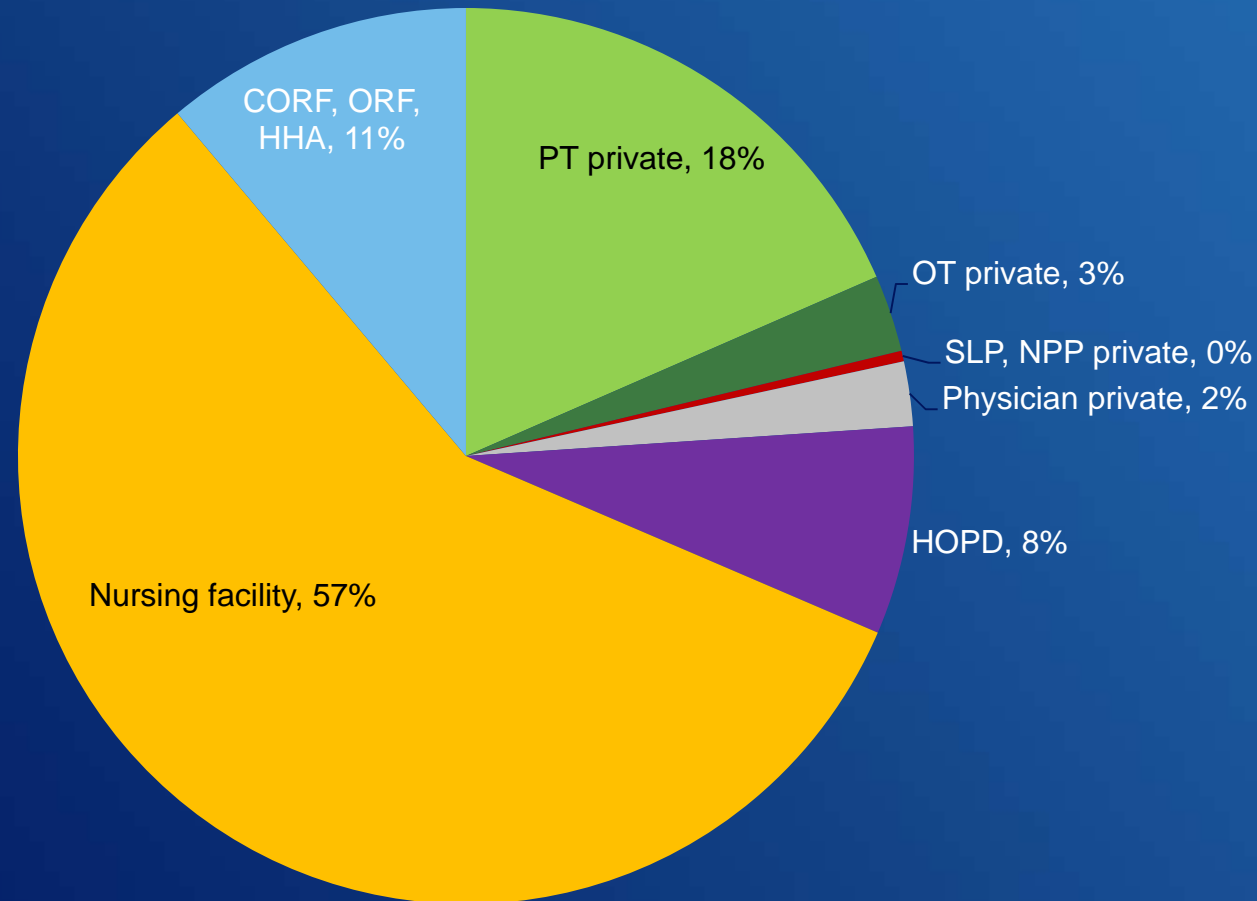
Source: MedPAC analysis of 100% Medicare claims data.

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).

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% |

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