Testimony before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Hearing on "Examining Bipartisan Legislation to Improve the Medicare Program"

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Statement of Justin Moore, PT, DPT
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On behalf of
The American Occupational Therapy Association (AOTA)
The American Physical Therapy Association (APTA)
The American Speech-Language-Hearing Association (ASHA)

Chairman Burgess, Ranking Member Green, and Members of the Health Subcommittee of the House Committee on Energy and Commerce:

My name is Justin Moore, and I am the CEO of the American Physical Therapy Association. On behalf of the American Occupational Therapy Association (AOTA), the American Speech-Language-Hearing Association (ASHA), and the American Physical Therapy Association (APTA), I thank you for the opportunity to provide testimony on bipartisan legislation to strengthen and improve the Medicare program. Today I will share with you our perspective on a particular policy—the exceptions process to the limitations on therapy services under Medicare Part B, which is set to expire on December 31, 2017.

The therapy caps, and the current exceptions process to them, impact a wide spectrum of patients needing rehabilitation services. In particular, the therapy caps have a disproportionate impact on older, more chronically ill beneficiaries from underserved areas, such as rural and urban population centers. Advocacy work to protect access to therapy services for these patients and consumers has resulted in almost 30 patient and professional organizations coming together with the common objective to repeal the therapy caps once and for all. I want to thank Representatives Erik Paulsen, Ron Kind, Marsha Blackburn, and Doris Matsui for championing repeal of the therapy caps by introducing H.R. 807, which currently has 177 cosponsors in the House. Companion legislation has been introduced in the Senate by Senators Ben Cardin, Dean Heller, Susan Collins, and Bob Casey. This legislation has the bipartisan support of 26 senators as of today.

Since 1997, we have worked to ensure that this arbitrary limitation on outpatient rehabilitation

services does not impede access to necessary and covered care for Medicare beneficiaries. Congress has acted 16 times to prevent this policy from negatively impacting seniors and individuals with disabilities. Today, we ask that Congress fully address this longstanding concern by repealing the therapy caps and replacing them with a thoughtful medical review policy that will protect the integrity of Medicare while ensuring timely access to care. While we appreciate the committee's focus on the issue of the therapy caps, we urge the committee to avoid extending the exceptions process again, and instead pursue a permanent fix to the therapy cap.

While the current exceptions process has provided temporary mitigation for beneficiaries against the negative impact of the therapy caps, it is not a long-term solution.

We believe it is time for Congress to fully repeal the therapy caps and replace the temporary exceptions process with a permanent fix that is more targeted, ensures that care is delivered to vulnerable patients, streamlines the ability of providers to deliver needed care, and ensures the long-term viability of the Medicare program.

Background of the Outpatient Therapy Caps

As part of the Balanced Budget Act (BBA) of 1997, Congress authorized $1,500 therapy caps on the majority of outpatient therapy services furnished under Medicare Part B: in private practice settings, physician offices, skilled nursing facilities (Part B), comprehensive outpatient rehabilitation facilities, home health agencies (Part B), and rehabilitation agencies. At the time, Congress exempted outpatient hospital settings from the therapy cap.

Due to a quirk in statutory language, it was determined that 2 caps would exist: 1 on physical therapy and speech-language pathology combined and 1 on occupational therapy services. The therapy caps authorized in the BBA were designed to be a temporary measure until the Centers for Medicare and Medicaid Services (CMS) provided an alternative payment methodology for therapy services for Congress' consideration. The authorizing language from BBA also provided for inflationary growth beginning in 2002 for the financial limit. Today the therapy cap is $1,980 per beneficiary per year for physical therapy and speech-language language pathology services, and $1,980 per beneficiary per year for occupational therapy, with a clinically based exceptions process.

The therapy caps originally went into effect on January 1, 1999, but were not enforced due to limitations in implementing them at the agency and local contractor level. On November 19, 1999, Congress passed the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, which placed a 2-year moratorium on the $1,500 cap for 2000 and 2001. Congress passed legislation again in 2000 as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to extend the moratorium on the therapy caps through 2002. In 2003, CMS delayed enforcement of the therapy cap from January 1, 2003, through September 1, 2003. The therapy cap was in place from September 1, 2003, until Congress passed the Medicare Modernization Act on December 8, 2003, that extended the moratorium on the therapy cap through December 31, 2005. In other words: In the first 6 years of the therapy cap, Congress passed moratoriums on this policy 3 times, and the caps were in effect for just under 100 days.

The therapy caps again went into effect temporarily on January 1, 2006, but were quickly addressed in the Deficit Reduction Act passed by Congress on February 1, 2006, by creation of the initial exceptions process. Originally, CMS implemented a 2-tier approach of an automatic exceptions process for certain diagnoses likely to exceed the therapy cap and a manual process for clinicians to provide justification of medically necessary care above the arbitrary financial limitation of the therapy cap. Due to the difficulty in reviewing all claims submitted under the manual process, the exceptions process was modified to allow for the use of a code-based modifier to signify that therapy services above the financial limit are medically necessary and appropriate.

The Middle Class Tax Relief and Job Creations Act of 2012 implemented a manual medical review (MMR) process that began in October 2012. This process initially required a MMR of all claims over the $3,700 threshold, prior to the services being provided. Later these reviews were handled as prepayment reviews by Medicare Administrative Contractors (MACs), and then CMS used Recovery Audit Contractors (RACs) to do prepayment reviews of claims in 12 states and postpayment reviews of claims in the other 38.

In addition to RACs being inappropriate contractors to review services that have never been paid for, the entire process of review was poorly administered and never implemented in a way that did not create a burden for providers. This was particularly true of the preapproval process (similar to the issues experienced with preapproval in 2006). The MMR process was put on hold in 2014 and 2015 due to contract issues.

In 2015 the Medicare Access and CHIP Reauthorization Act put into place a *targeted* MMR process, based on set criteria. From the perspective of the 3 therapy groups, this process has worked without undue burden or delaying care for beneficiaries. The current extension of the therapy cap exceptions process expires on December 31, 2017.

The Impact

It has been estimated that almost 70% of Medicare beneficiaries have more than 1 chronic condition that may require outpatient therapy. For a patient with multiple chronic conditions, therapy services are critical to preserving or regaining function following an impairment or a major medical condition such as stroke. Medicare beneficiaries requiring extensive or multiple therapies most likely will quickly exceed the therapy cap benefit. Although the exceptions process is in place to provide a pathway to care for these individuals, the current process is only guaranteed through the end of this year.

The combined cap of physical therapy and speech-language pathology is also problematic, as these are distinct clinical services that occur at different times in the continuum of care. They address related but separate areas of impairment. A patient with a stroke might receive extensive physical therapy to regain mobility, but then the cap will limit their ability to obtain services to improve swallowing or speaking. This example of giving the patient a choice between walking and talking is an oft-cited example of the complicating factors and poor policy of the therapy cap.

Additionally, services under Medicare are required to be medically necessary, and providers must meet the required regulations to demonstrate this requirement. The therapy cap places an arbitrary stopping point to therapy regardless of the medical necessity of the services. A patient has a demonstrated need for care, and yet a policy overrides their ability to receive that care. This runs contrary to the overall policies of Medicare related to ensuring quality patient outcomes.

Congress has long known that allowing the therapy caps to go into effect would have a profound impact on patient care; that is clear from the repeated delays and extensions of the exceptions process. But the pattern of yearly extensions without a permanent solution is not in the best interest of patients, providers, or the Medicare program, as it creates uncertainty for beneficiaries and providers. We recognize and appreciate the cost of a permanent fix and appreciate Congress' work to ensure that hard caps on therapy services do not go into effect. However, the cost of a permanent fix will only continue to rise as more beneficiaries come into the Medicare system. Additionally, it appears that new models of care are discharging patients from inpatient settings earlier, and relying more and more on outpatient settings for the provision of therapy services. While these models may save the entire Medicare system money, they are shifting services from Part A to Part B. Should this pattern continue, the cost of repealing the therapy caps down the road will only increase, and so too will the negative impact on patients and outcomes. The 20 years of exceptions process extensions now has cost more than that of a permanent fix, so we urge Congress to move forward toward a solution this year, which would avoid a future of additional costly extensions.

ASHA, APTA, and AOTA believe simply extending the exceptions process yet again is not in the best interest for sustaining the long-term fiscal health of Medicare, nor does it meet the growing needs for cost-effective rehabilitation services under Medicare. The time has come to enact a replacement policy that is a permanent fix. Such a policy should build upon the lessons learned and data gathered through the current exceptions process, and current and previous medical review programs.

Current Exceptions Process and Medical Review

With the passage of MACRA, the exceptions process to the therapy caps is currently in effect. Under this system, providers may request an exception on a beneficiary's behalf when their treatment exceeds the cap—$1,980 in 2017—and the services are determined to be medically necessary. To indicate this medical necessity, the therapy provider or practitioner is required to add a KX modifier to the claim for each applicable service. By using the KX modifier, the provider attests both that (a) the services are reasonable and necessary, and (b) there is documentation of medical necessity in the beneficiary's medical record.

A second layer to the current therapy caps exceptions process is a targeted review of claims once a beneficiary's incurred expenses reaches a threshold of $3,700. Each beneficiary's incurred expenses apply toward the threshold in the same manner as it applies to the therapy caps. There's 1 threshold for combined PT and SLP services and another threshold for OT services.

This current medical review process allows CMS to do a targeted review of claims that exceed the $3,700 threshold rather than a review *every* claim above the threshold, as was required when

the exceptions process was first implemented in 2006 and when medical review was first implemented in 2012. Targeted medical review focuses more on providers with aberrant billing patterns when compared with their peers, or that have a high amount of hours or minutes of therapy delivered to patients in a single day. This review occurs after therapy services have been provided.

Lessons Learned That Inform a Replacement Proposal

AOTA commissioned a report from the Moran Company to look at patterns in therapy utilization that might inform policy for a permanent fix. This report compared therapy utilization in 2011 (the year before medical review was implemented at the $3,700 threshold) with 2015 (when the refined review process was first implemented). The data demonstrate 2 key findings:

First, the average per-beneficiary, Part B therapy spending *decreased* by 8% across all therapy types between 2011 and 2015. This compares with an *increase* of 8% in overall beneficiary Part B spending. This demonstrates that the current process of reviewing targeted claims over the $3,700 threshold is working. Between 2011 and 2015 the proportion of overall spending above the $3,700 threshold fell from 31% to 20% of total Medicare therapy spending for physical therapy and speech language pathology, and from 35% to 27% of occupational therapy spending. This decrease in total Medicare therapy spending on services above the threshold is the result of both a decrease in the number of beneficiaries receiving services over the threshold and a decrease in the average cost per beneficiary over the threshold. (Moran analysis Tables 3 and 4 attached).

Second, this data demonstrates that while there has been a decrease in spending above the threshold, services are still being provided and approved by the current review process. The current $3,700 threshold and medical review process appear to be having the intended effect of controlling potentially unnecessary utilization, as seen by a decrease in per-beneficiary spending and number of beneficiaries in this category, but still maintaining a pathway for patients to receive all medically necessary services.

Representatives from the 3 therapy professional organizations have been in discussion with both Energy and Commerce Committee and Ways and Means Committee staff, as well as with Senate Finance Committee staff, about ideas for a permanent therapy cap policy. We believe that the $3,700 threshold and current medical review process is providing appropriate oversight of therapy spending, and could be incorporated and improved in a permanent fix to ensure continuity of care, increased efficiencies, and decreased administrative burden.

One possible policy for a permanent fix could include a 3-step process of oversight of therapy claims. The first step would be to utilize the current $3,700 threshold as a trigger for *postpayment* medical review of claims submitted by providers who meet certain criteria. Additional oversight mechanisms could be utilized for providers on postpayment medical review who are identified as meeting additional factors; in other words, providers who are not "succeeding" under postpayment review. This oversight coupled with a pathway for therapy providers to be part of alternative payment models and other performance-based models will better align therapy services with the transition of Medicare to a value-based system.

To that end, and based on our experience with previous policies, we respectfully propose the following principles:

1) Ensuring patient access

Any permanent therapy cap policy should—at its core—ensure patient access to outpatient therapy services. The fundamental flaw with the policy of the therapy cap is that it is a broad barrier to care that does not take into account the individual needs of the patient. Additionally, any new policy should ensure that care is not disrupted for long periods of time. In the past, when CMS has been asked to do a broad review of a large number of claims, they have been unable to efficiently implement the policy, resulting in delayed care for patients and high administrative burden for providers. Not only is delayed care bad for the patient, but it could lead to higher costs to the program, as the beneficiary's progress may regress if care is disrupted.

2) Targeted approach to oversight of outpatient therapy spending

We support a mechanism to ensure appropriate delivery and utilization of outpatient therapy services. This could include targeted reviews of therapy providers whose claims exceed certain thresholds and have been identified based on specific factors. Additional scrutiny could be given to providers who continue to have claims rejected under the review process. However, any additional scrutiny, whether through postpayment review or preauthorization, should include protections for patients and ensure that care is not delayed (see principle #1). This process would be similar to the current $3,700 threshold and postpayment medical review process. Blanket mechanisms, such as the current therapy caps or broad application of prior authorization across the patient spectrum, are not effective. They restrict patient access, do not take into account

medical severity, interrupt the continuity of care, and cannot realistically be implemented by CMS.

3) Alignment with value-based and performance-based models

We believe that therapy services provided in a qualifying Alternative Payment Model (APM) should be exempt from any permanent outpatient therapy policy. Providers who participate in APMs would already be subject to quality and outcome requirements, as well as a shared risk for the cost of care, that would ensure efficient provision of services. In addition, while therapy providers are not currently part of the MIPS program, we anticipate that these providers will be added to the program in 2019. The MIPS program provides performance-based penalties and payment adjustments to providers. Under MIPs, the therapy caps and ongoing short-term fixes could impede the ability of providers to maximize outcomes, decrease costs, and improve performance. A permanent fix is essential in order for therapy providers to effectively participate in MIPS.

Conclusion

In closing, ASHA, AOTA, and APTA, along with other members of the community opposing the therapy cap, stand ready to work with the Committee to finally, after 20 years of extensions and moratoria, to repeal the therapy cap, find a permanent fix that ensures patients' access, improves the care delivered to those patients, streamlines the ability of providers to deliver that care, and ensures the long-term viability of the Medicare program. Thank you.

Memorandum (March 10, 2017)

To: **Christina Metzler, American Occupational Therapy Association (AOTA)**

From: **Peter Kardel, Peter Gruhn, Rachel Kramer**

Subject: **Analysis of the Distribution of Part B Outpatient Therapy Spending in Relation to the Medicare Outpatient Therapy Cap**

The Moran Company (TMC) was tasked with analyzing Medicare spending on Part B outpatient therapy services in relation to the mandated annual caps on the therapy services using the most current year of available data (2015) and a prior comparison year (2011). Specifically, the American Occupational Therapy Association (AOTA) is interested in better understanding the volume of spending (and number of beneficiaries) that exceeds the annual therapy cap amount and the volume that exceeds the targeted medical review amount.[1] With a better understanding of the distribution of therapy spending among fee for service Medicare beneficiaries, the impact of various cap thresholds may be calculated and assessed. AOTA is also interested in total therapy spending by place of service, with specific attention to Skilled Nursing Facility (SNF) and Hospital Outpatient Department (HOPD) settings.

Key Findings

- Nearly 6 million[2] beneficiaries received Part B outpatient therapy services in 2015 which produced nearly $8 billion in total Medicare spending (see Table 1).[3]
- Whereas the percentage of beneficiaries utilizing Part B therapy services increased by about 16% over the four year period compared to a 4% increase in the percentage of beneficiaries utilizing Part B services overall, total Part B Medicare spending increased by about 11% while spending for therapy services increased by only 7% over the period.
- Despite an increase in beneficiaries and total Part B Medicare therapy spending across our comparison years, the average per beneficiary therapy Medicare spending went down 8% across all therapy types with a mean spend of $1,466 (standard deviation [SD] = $2,231) in 2011 to a mean of $1,348 (SD = $1,885) in 2015 (see Table 2).[4]
- Overall, 84% of beneficiaries (4.7M) fell below the physical therapy (PT)/speech language pathology (SLP) therapy cap in 2015. For those above the cap, only 4% were

[1] In 2015, the annual therapy cap was $1,940 and the targeted medical review was set at $3,700.
[2] Totals are projected to 100% from the 5% Medicare Standard Analytic Files (SAFs).
[3] By contrast, about 36.5 million beneficiaries utilized Part B services in 2015, representing about $216 billion in total Part B Medicare related spending.
[4] By contrast, average total spending per beneficiary utilizing Part B services increased by 8% over the period from 2011 to 2015.

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above the medical review threshold which made up 20% of the PT/SLP therapy total Medicare spend (see Table 3).

- Between 2011 and 2015, the proportion of beneficiaries that utilized PT/SLP services and had spending above the medical review threshold declined from 6% to 4% over the period, while the proportion of spending declined from 31% to 20% of total Medicare PT/SLP spending over the period.
- Overall, 81% of beneficiaries (1.0M) fell below the OT therapy cap in 2015. For those above the cap, 6% were above the medical review threshold which made up 27% of the OT therapy total Medicare spend (see Table 4).
- Between 2011 and 2015, the proportion of beneficiaries that utilized OT services and had spending above the medical review threshold declined from 8% to 6% over the period, while the proportion of spending declined from 35% to 27% of total Medicare PT/SLP spending over the period.
- Mean total Medicare spending per beneficiary for OT and PT/SLP was highest in the SNF setting (see Tables 5 & 6).
- Of all PT/SLP beneficiaries above the therapy cap threshold:
    - 35% of beneficiaries received therapy in a SNF which accounted for 41% of the total PT/SLP spending above the cap (see Table 7).
    - 15% of beneficiaries received therapy in the HOPD which accounted for 8% of the total PT/SLP spending above the cap (see Table 7).
- Of all OT patients above the therapy cap threshold:
    - 73% of beneficiaries received therapy in a SNF which accounted for 74% of the total OT spending above the cap (see Table 8).
    - 7% of beneficiaries received therapy in a HOPD which accounted for 3% of the total OT spending above the cap (see Table 8).
- Of those beneficiaries who received outpatient therapy in the SNF:
    - 41% exceed the PT/SLP therapy cap and account for 75% of the PT/SLP spending in the SNF (Table 9).
    - 32% exceed the OT therapy cap and account for 66% of OT spending in the SNF (Table 10).
- Of those beneficiaries who received outpatient therapy in the HOPD:
    - 7% exceed the PT/SLP therapy cap and account for 23% of PT/SLP spending in the HOPD (Table 11).
    - 5% exceed the OT therapy cap and account for 19% of OT spending in the HOPD (Table 12).
- We modeled alternative therapy cap scenarios including the number of beneficiaries and the percent of therapy spending that would fall under any given alternative therapy cap specification (Tables 13, 14). For example:

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- Increasing the annual OT per beneficiary cap amount to $2,889 would cover 90% of the Part B beneficiaries receiving OT services and 85% of all Part B OT spending.

The remainder of this memorandum provides additional detail on the results of this analysis and is organized in the following sections:

- Examination of Spending by Type of Therapy
- Average Annual Therapy Spending per Beneficiary
- Examination of Spending Above the Therapy Cap
- Examination of Spending by Place of Service (POS)
- Average Annual Therapy Spending per Beneficiary by POS
- Examination of All Beneficiaries Above/Below the Cap by POS
- Examination of Spending by Therapy Cap for those Beneficiaries in SNF
- Examination of Spending by Therapy Cap for those Beneficiaries in HOPD
- Analysis of Various Cap Thresholds – OT
- Analysis of Various Cap Thresholds – PT/SLP
- Appendix A - Figures
- Appendix B - Methodology

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Examination of Spending by Type of Therapy

In 2015, of the 36.5 million beneficiaries that utilized Part B services, nearly 6 million received Part B therapy services which totaled to nearly $8 billion in total Medicare spending. The percentage of beneficiaries utilizing Part B therapy services increased by about 16% over the four year period compared to a 4% increase in the percentage of beneficiaries utilizing Part B services overall. While the percentage increase in beneficiaries utilizing part B therapy services was about four times the percentage increase in beneficiaries utilizing Part B services, total Medicare spending for Part B therapy services increased by only 7%, while overall total Medicare spending for Part B services increased by about 11% over the period.

The majority of beneficiaries utilizing Part B therapy services received PT (90%). By contrast, about 22% received OT services, and only 11% received SLP services. The distribution of beneficiaries utilizing therapy services by therapy discipline, as well as total Medicare therapy spending by therapy discipline remained relatively constant between 2011 and 2015.

Table 1 – Beneficiary Count and Total Medicare Spending for Therapy, by Therapy Type & Year

	2011				2015				Percent Change (2011-2015)	
	Number of Beneficiaries		Total Medicare Spending		Number of Beneficiaries		Total Medicare Spending		Beneficiaries	Total Medicare Spending
	n	%	$ (million)	%	n	%	$ (million)	%	%	%
Total Therapy	5,090,220	100%	$7,464.8	100%	5,902,080	100%	$7,955.1	100%	16%	7%
- PT/SLP	4,786,020	94%	$6,103.8	82%	5,569,660	94%	$6,453.1	81%	16%	6%
- PT	4,533,640	89%	$5,427.1	73%	5,313,900	90%	$5,820.8	73%	17%	7%
- SLP	553,220	11%	$676.6	9%	631,760	11%	$632.3	8%	14%	-7%
- OT	1,088,100	21%	$1,361.0	18%	1,278,420	22%	$1,502.0	19%	17%	10%

Average Annual Therapy Spending per Beneficiary

The relatively slower rate of increase in total Medicare therapy spending compared to the number of beneficiaries utilizing therapy services results in an 8% reduction in average total Medicare therapy spending per beneficiary over the four year period, while total Medicare part B spending per beneficiary increased by about 8% over the period. The reduction in therapy spending per beneficiary was across the board for beneficiaries utilizing different types of therapy services. For example, average spending for PT/SLP combined fell by about 9% over the four year period, while average spending for OT services fell by 6%. SLP saw the largest reduction, with average Medicare spending per beneficiary for SLP services declining by about 18% over the four year period.

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Table 2 – Average Medicare Spending for Therapy, by Therapy Type & Year

	Number of Beneficiaries				Total Medicare Spending				
	2011		2015		2011		2015		Percent
	n	%	n	%	Average	Std Dev	Average	Std Dev	Change
Total Therapy	5,090,220	100%	5,902,080	100%	$1,466	$2,231	$1,348	$1,885	-8%
- PT/SLP	4,786,020	94%	5,569,660	94%	$1,275	$1,693	$1,159	$1,351	-9%
- PT	4,533,640	89%	5,313,900	90%	$1,197	$1,469	$1,095	$1,166	-8%
- SLP	553,220	11%	631,760	11%	$1,223	$1,710	$1,001	$1,312	-18%
- OT	1,088,100	21%	1,278,420	22%	$1,251	$1,669	$1,175	$1,488	-6%

Examination of Spending Above Therapy Cap

We also assessed where beneficiaries fall in regards to the therapy caps. For this analysis, we placed beneficiaries into one of three groups based on annual Medicare PT/SLP or OT spending: at or below the therapy cap, between the therapy cap and medical review threshold, and above the medical review threshold.

Within the examination of PT/SLP therapy utilization (Table 3), 84% of beneficiaries were below the therapy cap which consisted of 52% of total PT/SLP spending in 2015. Notably, the remaining 16% of beneficiaries totaled nearly half (48%) of the PT/SLP spending. While 4% of beneficiaries were above the medical review threshold, and these beneficiaries made up 20% of the PT/SLP spending in 2015 ($1,291.6M), the proportion of spending by these beneficiaries above the medical review threshold decreased by 31% from 2011 to 2015.

Table 3 – PT/SLP Utilization and Spending by Therapy Cap Threshold

	Beneficiaries					Total Medicare Spending				
	2011		2015		Percent	2011		2015		Percent
	n	%	n	%	Change	$ (million)	%	$ (million)	%	Change
Beneficiaries Using PT/SLP Therapy Services	4,786,020	100%	5,569,660	100%	16%	$6,103.8	100%	$6,453.1	100%	6%
Beneficiaries At or Below Therapy Cap	3,860,000	81%	4,653,060	84%	21%	$2,643.0	43%	$3,332.6	52%	26%
Beneficiaries Between Therapy Cap and Medical Review Threshold	621,460	13%	693,580	12%	12%	$1,585.3	26%	$1,828.9	28%	15%
Beneficiaries Above Medical Review Threshold	304,560	6%	223,020	4%	-27%	$1,875.5	31%	$1,291.6	20%	-31%

As seen in Table 4, about 81% of beneficiaries utilizing OT services remained below the OT therapy cap in 2015. The 19% of beneficiaries above the cap comprised nearly 60% of total Medicare OT spending, and the 6% of beneficiaries above the medical review threshold were responsible for about 27% of total Medicare OT spending. The proportion of beneficiaries above the medical review threshold declined between 2011 and 2015 (about 10%), and total Medicare therapy spending for this group declined by about 14%.

Table 4 – OT Utilization and Spending By Therapy Cap Threshold

	Beneficiaries					Total Medicare Spending				
	2011		2015		Percent	2011		2015		Percent
	n	%	n	%	Change	$ (million)	%	$ (million)	%	Change
Beneficiaries Using OT Therapy Services	1,088,100	100%	1,278,420	100%	17%	$1,361.0	100%	$1,502.0	100%	10%
Beneficiaries At or Below Therapy Cap	861,120	79%	1,030,580	81%	20%	$507.9	37%	$623.0	41%	23%
Beneficiaries Between Therapy Cap and Medical Review Threshold	144,600	13%	174,080	14%	20%	$375.3	28%	$466.4	31%	24%
Beneficiaries Above Medical Review Threshold	82,380	8%	73,760	6%	-10%	$477.8	35%	$412.6	27%	-14%

Examination of Spending by Place of Service (POS)

As seen in Figure 1 (below), over one third of overall therapy services spending was incurred in the office setting, followed closely SNF, and then HOPD. These proportions were relatively stable across comparison years.[5]

Figure 1 – Total Payments by Place of Service in 2015

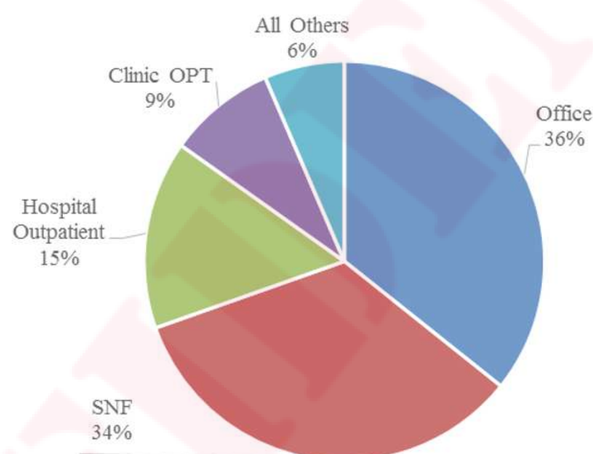

Figure 2 (below) also provides a summary of payments by place of service for PT/SLP and OT. Similar to the overall figure (above), spending for PT/SLP was mainly found in services provided in the office, then SNF, and HOPD. For OT, by contrast, the majority of payments were incurred in the SNF (65%), followed by HOPD and office (both at 10%).

[5] See workbook tab entitled "Figure 1. POS Examination" for totals across both years of study.

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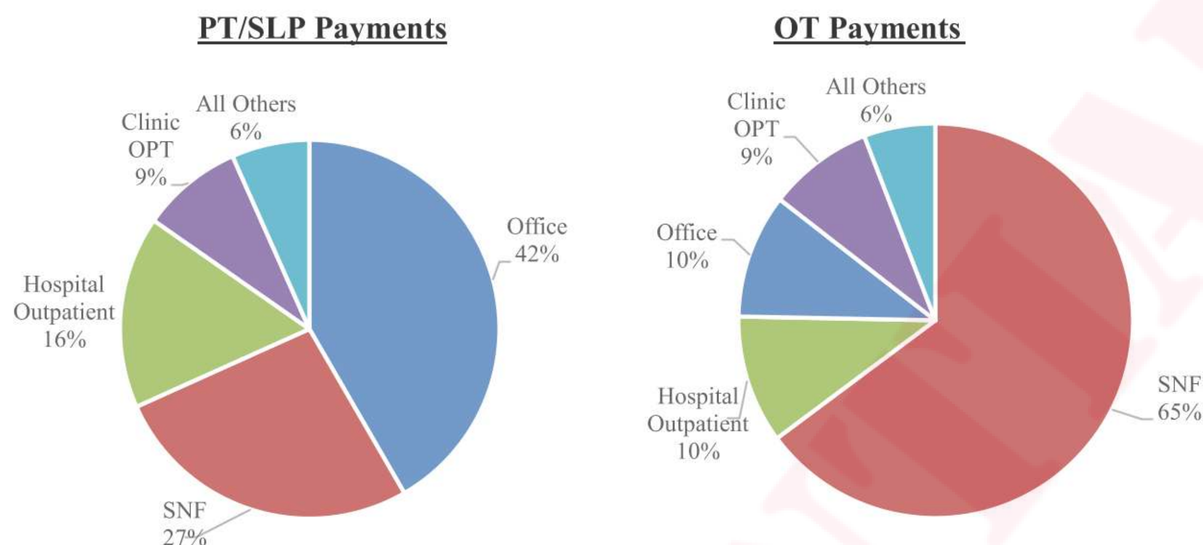
Figure 2 – Total PT/SLP and OT Payments by Place of Service in 2015



Average Annual Total Medicare Therapy Spending per Beneficiary by POS

In order to better understand changes to therapy provided and/or billing practices across the comparison years, we computed the average total Medicare therapy spending by POS within each therapy type.

Table 5 summarizes the average spend by POS for PT/SLP, and it shows a relatively uniform decrease in per beneficiary spend among POS settings across the comparison years. The largest per beneficiary spend in 2015 was found in the SNF setting ($2,126 per year), where average spending per beneficiary declined by only 1% over the period. By contrast, average HOPD spending per PT/SLP beneficiary declined by about 16% over the period.

Table 5 – Per Beneficiary Medicare Spend for PT/SLP Services, by POS

	Beneficiaries			Average Medicare Spending				
	2011	2015	Percent	2011		2015		Percent
	%	%	Change	Average	Std Dev	Average	Std Dev	Change
Beneficiaries Using PT/SLP Therapy Services	100%	100%	N/A	$1,275	$1,693	$1,159	$1,351	-9%
Office	44%	45%	3%	$1,163	$1,347	$1,071	$984	-8%
HOPD	31%	32%	4%	$698	$1,063	$589	$726	-16%
SNF	16%	15%	-11%	$2,146	$2,555	$2,126	$2,218	-1%
All Other	16%	15%	-5%	$1,264	$1,596	$1,173	$1,328	-7%

Table 6 summarizes the average spend per beneficiary by POS for OT. Overall, average OT spending per beneficiary was $1,175 per year in 2015. Average spending was highest in the SNF setting ($1,741 per year), and lowest in HOPD settings ($391 per year). While overall spending declined by about 6% over the period, the decline was not proportional across POS settings. Average spending per beneficiary for OT services in the office setting declined by about 11% over the four year period, and declined most dramatically in the HOPD setting, where it fell by 25% over the period.

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Table 6 – Per Beneficiary Medicare Spend for OT Services, by POS

	Beneficiaries			Average Medicare Spending				
	2011	2015	Percent	2011		2015		Percent
	%	%	Change	Average	Std Dev	Average	Std Dev	Change
Beneficiaries Using OT Therapy Services	100%	100%	N/A	$1,251	$1,669	$1,175	$1,488	-6%
Office	15%	15%	0%	$920	$1,367	$815	$983	-11%
HOPD	28%	31%	12%	$524	$850	$395	$591	-25%
SNF	47%	44%	-6%	$1,689	$1,877	$1,741	$1,710	3%
All Other	14%	14%	0%	$1,291	$1,699	$1,216	$1,575	-6%

Examination of All Beneficiaries Below/Above the Cap by POS

In 2015, beneficiaries receiving therapy in the SNF made up 35% of all beneficiaries above the PT/SLP cap while also accounting for 41% of total spending above the cap (Table 7).

Table 7 – PT/SLP Utilization and Spending by Therapy Cap Threshold Across POS

		Beneficiaries Below Therapy Cap				Beneficiaries Above Therapy Cap*			
		n	%	$ (million)	%	n	%	$ (million)	%
	All POS	3,860,000	100%	$2,643.0	100%	926,020	100%	$3,460.8	100%
	SNF	480,520	12%	$390.7	15%	298,860	32%	$1,281.8	37%
2011	**HOPD**	1,292,480	33%	$637.8	24%	185,720	20%	$393.6	11%
	All POS	4,653,060	100%	$3,332.6	100%	916,600	100%	$3,120.5	100%
	SNF	484,700	10%	$429.5	13%	324,920	35%	$1,291.6	41%
2015	**HOPD**	1,648,540	35%	$813.9	24%	141,700	15%	$241.1	8%

**Includes both categories of "Between Therapy Cap and Medical Review" and "Above Medical Review"*

In 2015, beneficiaries receiving outpatient therapy within the SNF made up 73% of all beneficiaries above the OT cap while also accounting for 74% of total spending above the OT cap (Table 8).

Table 8 - OT Utilization and Spending by Therapy Cap Threshold Across POS

		Beneficiaries Below Therapy Cap				Beneficiaries Above Therapy Cap*			
		n	%	$ (million)	%	n	%	$ (million)	%
	All POS	861,120	100%	$507.9	100%	226,980	100%	$853.1	100%
	SNF	352,880	41%	$274.1	54%	154,660	68%	$583.1	68%
2011	**HOPD**	280,460	33%	$101.0	20%	23,480	10%	$58.3	7%
	All POS	1,030,580	100%	$623.0	100%	247,840	100%	$879.0	100%
	SNF	379,060	37%	$326.4	52%	180,540	73%	$647.8	74%
2015	**HOPD**	380,880	37%	$126.9	20%	17,880	7%	$30.5	3%

**Includes both categories of "Between Therapy Cap and Medical Review" and "Above Medical Review"*

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Examination of Spending by Therapy Cap for those Beneficiaries in the SNF Only

As requested, we took a closer look at beneficiaries receiving therapy treatment in the SNF and HOPD. Tables 9 & 10 present beneficiary and spending information in relation to the therapy cap for those beneficiaries who receive Part B therapy in the SNF.

Of those beneficiaries who receive PT/SLP in the SNF setting, 41% exceed the PT/SLP therapy cap (as seen in Table 9 by combining both groups above the cap). These beneficiaries account for 75% of the PT/SLP spending ($1,291.7M) in the SNF.

Table 9 – PT/SLP Utilization and Spending by Therapy Cap Threshold within the SNF POS

	Beneficiaries					Total Medicare Spending				
	2011		2015		Percent	2011		2015		Percent
	n	%	n	%	Change	$ (million)	%	$ (million)	%	Change
Beneficiaries Using PT/SLP Therapy Services in SNF	779,380	100%	809,620	100%	4%	$1,672.5	100%	$1,721.1	100%	3%
Beneficiaries At or Below Therapy Cap	480,520	62%	484,700	60%	1%	$390.7	23%	$429.5	25%	10%
Beneficiaries Between Therapy Cap and Medical Review Threshold	163,360	21%	198,700	25%	22%	$413.6	25%	$526.4	31%	27%
Beneficiaries Above Medical Review Threshold	135,500	17%	126,220	16%	-7%	$868.2	52%	$765.3	44%	-12%

Of those beneficiaries who receive OT in the SNF setting, as seen in Table 10, 32% of beneficiaries (~181,000) exceed the therapy cap (when combing both groups) and account for 66% of spending ($647.8M).

Table 10 – OT Utilization and Spending by Therapy Cap Threshold within the SNF POS

	Beneficiaries					Total Medicare Spending				
	2011		2015		Percent	2011		2015		Percent
	n	%	n	%	Change	$ (million)	%	$ (million)	%	Change
Beneficiaries Using OT Therapy Services in SNF	507,540	100%	559,600	100%	10%	$857.2	100%	$974.1	100%	14%
Beneficiaries At or Below Therapy Cap	352,880	70%	379,060	68%	7%	$274.1	32%	$326.4	34%	19%
Beneficiaries Between Therapy Cap and Medical Review Threshold	96,580	19%	122,040	22%	26%	$248.6	29%	$324.9	33%	31%
Beneficiaries Above Medical Review Threshold	58,080	11%	58,500	10%	1%	$334.5	39%	$322.9	33%	-3%

Examination of Spending by Therapy Cap for those Beneficiaries in the HOPD Only

Tables 11 & 12 present summary information on beneficiaries and spending in relation to the therapy cap for those beneficiaries who receive Part B therapy in the HOPD setting.

Of those beneficiaries who receive PT/SLP in the HOPD setting, the majority (92% in 2015) fall below the therapy cap. Approximately 7% of beneficiaries in the HOPD setting were above the cap representing ~23% of therapy spending ($241.1M) above the cap.

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Table 11 – PT/SLP Utilization and Spending by Therapy Cap Threshold within the HOPD POS

	Beneficiaries					Total Medicare Spending				
	2011		2015		Percent	2011		2015		Percent
	n	%	n	%	Change	$ (million)	%	$ (million)	%	Change
Beneficiaries Using PT/SLP Therapy Services in HOPD	1,478,200	100%	1,790,240	100%	21%	$1,031.4	100%	$1,054.9	100%	2%
Beneficiaries At or Below Therapy Cap	1,292,480	87%	1,648,540	92%	28%	$637.8	62%	$813.9	77%	28%
Beneficiaries Between Therapy Cap and Medical Review Threshold	136,800	9%	115,420	6%	-16%	$242.9	24%	$180.6	17%	-26%
Beneficiaries Above Medical Review Threshold	48,920	3%	26,280	1%	-46%	$150.7	15%	$60.4	6%	-60%

Of those beneficiaries who receive OT in the HOPD setting, only ~5% are above the therapy cap in 2015, and they account for 19% of spending (see Table 12).

Table 12 – OT Utilization and Spending by Therapy Cap Threshold within the HOPD POS

	Beneficiaries					Total Medicare Spending				
	2011		2015		Percent	2011		2015		Percent
	n	%	n	%	Change	$ (million)	%	$ (million)	%	Change
Beneficiaries Using OT Therapy Services in HOPD	303,940	100%	398,760	100%	31%	$159.3	100%	$157.4	100%	-1%
Beneficiaries At or Below Therapy Cap	280,460	92%	380,880	96%	36%	$101.0	63%	$126.9	81%	26%
Beneficiaries Between Therapy Cap and Medical Review Threshold	17,600	6%	14,100	4%	-20%	$36.2	23%	$21.9	14%	-39%
Beneficiaries Above Medical Review Threshold	5,880	2%	3,780	1%	-36%	$22.1	14%	$8.6	5%	-61%

Analysis of Various Cap Thresholds – OT

We placed beneficiaries within centiles for their therapy spending in 2015. We were then able to calculate the per capita spending within each centile and examine the total spending if the therapy cap was placed at different centile thresholds. Using this technique, Table 13 summarizes the results using the 2015 OT data.[6] For example, the current OT therapy cap of $1,940 results in 81% of beneficiaries falling beneath the cap. However, if 85% of beneficiaries were to be covered then we estimate that the cap would need to be raised to $2,274. Further, the top 5% of beneficiaries utilizing OT related therapy services represent about 25% of total OT related spending. If the therapy cap were raised to $2,600, approximately 88 % of beneficiaries utilizing OT services would fall under the cap, rather than 81% currently.

Figure A in Appendix A provides a graphic summary of the total OT spending by centiles at the current cap level. Figure B also provides a graphical summary of the per capita amounts at each centile.

[6] Calculations for all centiles can be found in the accompanying Excel workbook.

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Table 13 – Results from OT Therapy Threshold Modeling Based on OT Total Spending Centiles

Beneficiary Spending Centile	Average Per Capita Spending	% of Total OT Medicaid Spending
81*	$1,933	42%
82	$2,010	44%
83	$2,091	46%
84	$2,179	47%
85	$2,274	49%
86	$2,382	51%
87	$2,500	54%
88	$2,622	56%
89	$2,753	58%
90	$2,889	61%
91	$3,036	63%
92	$3,202	66%
93	$3,381	69%
94	$3,560	72%
95	$3,771	75%
96	$4,083	78%
97	$4,532	82%
98	$5,214	87%
99	$6,256	92%
100	$9,259	100%

**Approximate centile of current therapy cap*

Analysis of Various Cap Thresholds – PT/SLP

Using the technique outlined above, Table 14 summarizes the results using the 2015 PT/SLP data. The current PT/SLP therapy cap of $1,940 results in 84% of beneficiaries falling beneath the cap. However, if 85% of beneficiaries were to be covered then we estimate that the cap would need to be raised to $2,013. Further, the top 5% of beneficiaries utilizing PT/SLP related therapy services represent about 23% of total PT/SLP related spending. If the therapy cap were raised to $2,600, approximately 90% of beneficiaries utilizing PT/SLP services would fall under the cap rather than 84% currently.

Figure C in Appendix A provides a graphic summary of the total PT/SLP spending by centiles at the current cap level. Figure D also provides a graphical summary of the per capita amounts at each centile.

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Table 14 – Results from PT/SLP Therapy Threshold Modeling Based on PT/SLP Total Spending Centiles

Beneficiary Spending Centile	Average Per Capita Spending	% of Total PT/SLP Medicaid Spending
84*	$1,937	52%
85	$2,013	54%
86	$2,095	56%
87	$2,185	58%
88	$2,285	60%
89	$2,394	62%
90	$2,516	64%
91	$2,651	66%
92	$2,797	69%
93	$2,959	71%
94	$3,140	74%
95	$3,347	77%
96	$3,575	80%
97	$3,904	83%
98	$4,488	87%
99	$5,573	92%
100	$9,208	100%

**Approximate centile of current therapy cap*

Conclusion

This memo provides the details of our analysis on Medicare spending for PT/SLP and OT service utilization in relation to the place of service and therapy cap designation. Please let us know if we can answer any questions.

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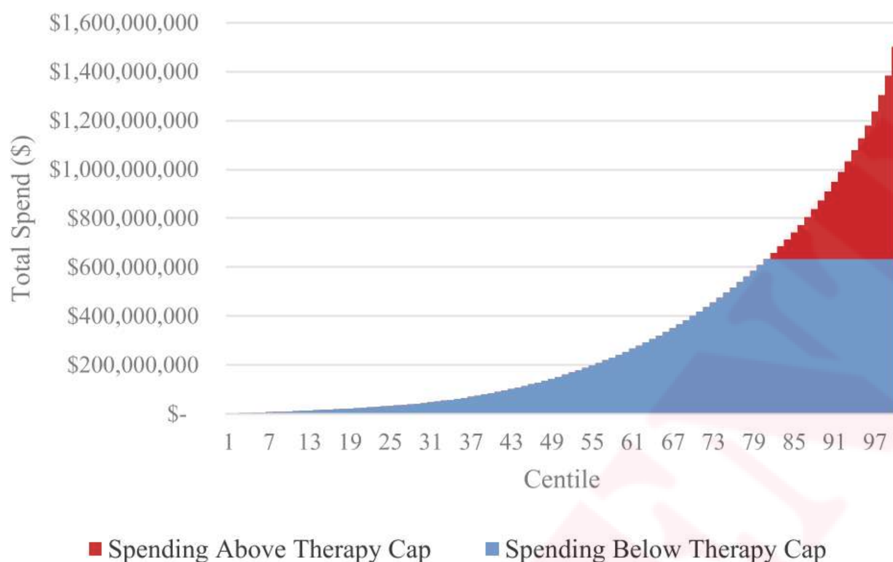
Appendix A – Figures

Figure A – 2015 OT Therapy Cumulative Spend By Beneficiary Total Spending Centile



Figures B - OT 2015 – Average Per Capita Spending By Beneficiary Total Spending Centile

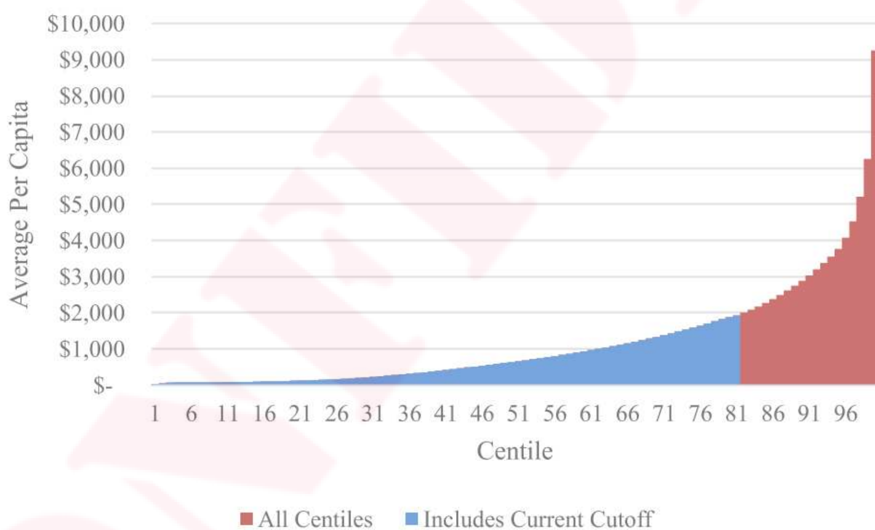


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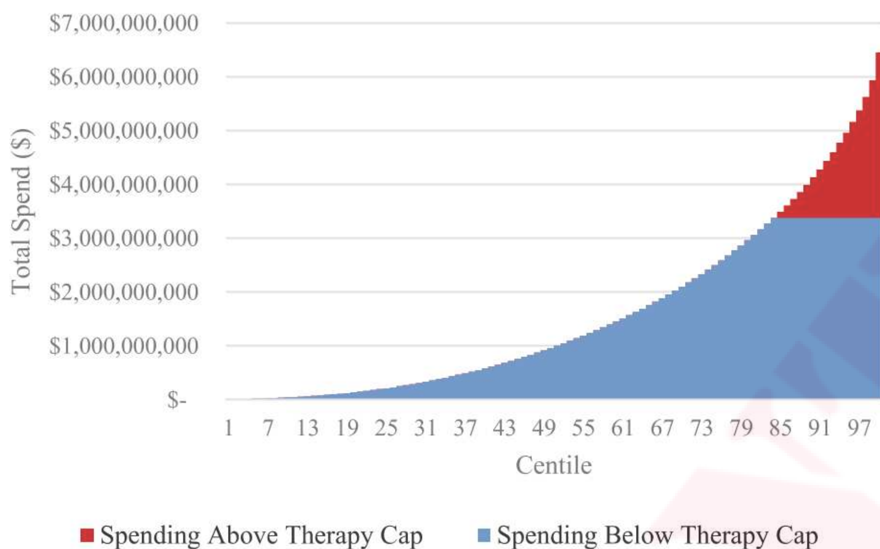
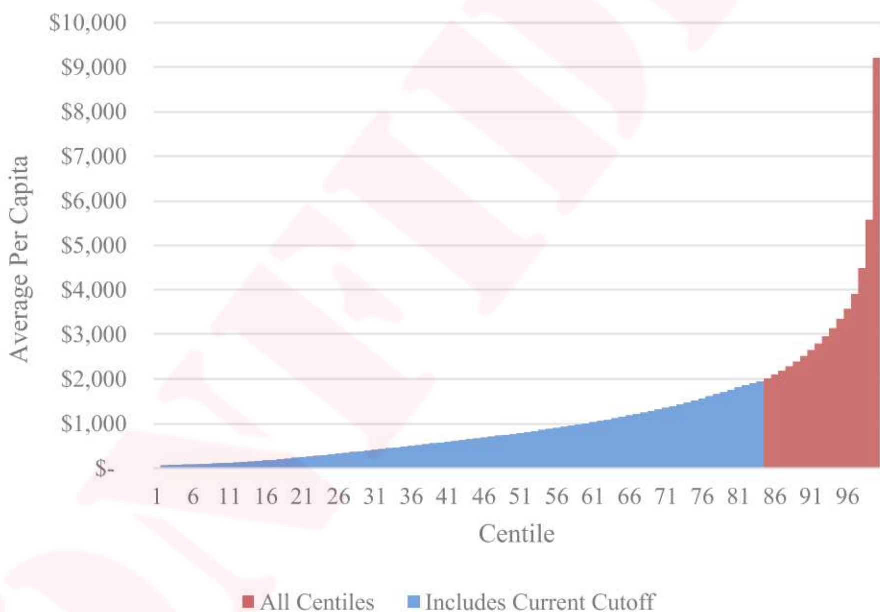
Figure C – 2015 PT/SLP Therapy Cumulative Spend By Beneficiary Total Spending Centile



Figures D - PT/SLP 2015 – Average Per Capita Spending By Beneficiary Total Spending Centile



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Appendix B - Methodology

Methodology

The Medicare Carrier and Outpatient 5% Standard Analytic Files (SAFs) were the source of all data in this study. Therapy services were identified using CMS's annual therapy update list for the applicable study years and included both always therapy services and sometimes therapy services. In both the 2011 and 2015 datasets, all claims with therapy service procedures[7] were extracted which included information on therapy-specific modifiers, place of service, and payment information. Therapy services were assigned to therapy cap categories (PT/SLP and OT) based on the presence of the applicable therapy modifier. Sometimes therapy procedures without a therapy-modifier (i.e., GN, GO, or GP) were dropped from all analyses. Additionally, therapy services were also excluded from analyses if there was $0 in total payment. A small proportion of the extracted procedures (<2%) were classified by CMS as always therapy codes, but the procedures did not have any therapy-modifier attached. In these instances, if these procedures had a provider specialty of 65, 15, or 67 (physical therapist, speech language pathologist, or occupational therapist, respectively), then the service was assigned to the applicable therapy cap modality based on provider specialty. Any other always therapy line with other specialty codes and no associated therapy modifier was dropped from the analysis (~1% of total procedures) as we did not have an immediate way to classify the claims into the applicable therapy modality. A similarly small percentage of procedures had multiple therapy modifiers on the same procedure (e.g., a procedure would have both a GP and GO modifier). In these cases, the modifier applicable to the case was assigned to align with the specialty of the therapy provider. If the provider was not a physical therapist, speech language pathologist, or occupational therapist and could thus not be assigned to a therapy cap classification, then the procedure was dropped from the analysis (<0.1% of procedures).

With data cleaned, all therapy procedures were then totaled, by therapy type, for each individual. Medicare spending was based on the allowed charges variable and includes Medicare as well as the beneficiary's portion of payment for the services.

[7] Each year within the analysis was scanned against its respective CMS-released list of therapy codes.

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