FACTSHEET

Hospital Outpatient Therapy Caps

THE ISSUE

Medicare has annual per beneficiary payment limits for outpatient therapy services (physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP)) provided by therapists and other eligible providers in certain settings. The caps – $1,880 in 2012 for all outpatient PT and SLP services combined, and $1,880 for all outpatient OT services – do not currently apply to therapy services patients receive in hospital outpatient departments.

In 2005, Congress passed an exceptions process to the therapy limit for cases in which the provision of additional therapy services was determined to be medically necessary. This exceptions process has been continuously extended in subsequent legislation. Most recently, the *Temporary Payroll Tax Cut Continuation Act of 2011* extended the therapy caps exceptions process through February 29, 2012.

Some policy makers are advocating expanding the outpatient therapy caps to the hospital outpatient setting. Specifically, the *House Middle Class Tax Relief & Job Creation Act of 2011* would extend the therapy caps exceptions process through December 31, 2013, expand the therapy caps to the hospital outpatient department setting, and establish a manual medical review process for high-cost beneficiaries (those with more than $3,700 in therapy services). The Congressional Budget Office estimates these three provisions would result in a net reduction in spending by $1.7 billion over 10 years.

AHA POSITION

While we support extending the outpatient therapy exceptions process, we strongly oppose expanding the therapy cap to therapy services provided in hospital outpatient departments.

WHY?

- **Hospital outpatient departments have stricter regulations that control the utilization of therapy services.** A physician must order outpatient therapy services performed in a hospital inpatient or outpatient setting. Therapists and other eligible providers are not able to initiate a plan of care without this order. Physician orders are not required for therapy services performed in other settings, such as in nursing homes or in therapists' private practices. In these cases, Medicare payment regulations require that the therapy plan of care be reviewed and certified by a physician within 30 days of the first therapy encounter and recertified at least every 90 days thereafter.
- **Hospital outpatient departments already receive lower payment for delivering the same exact therapy services.** Medicare pays for outpatient therapy according to fees established in the Physician Fee Schedule (PFS), regardless of where the services are provided. In the calendar year (CY) 2011 Medicare PFS rule, the Centers for Medicare & Medicaid Services (CMS) proposed a 25 percent multiple procedure payment reduction (MPPR) for therapy services that would apply across all settings. Before the rule was finalized, Congress adopted the *Physician Payment and Therapy Relief Act of 2010*, which codified a 20 percent MPPR for therapy services delivered in freestanding or office-based settings. The result is a site-of-service differential in payment, with therapy services in the hospital and institutional setting receiving a 25 percent MPPR and services in all other settings receiving a 20 percent reduction.

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- **The original therapy caps were intended as a cost control mechanism, but have not proven effective in saving Medicare money.** Congress has recognized that a financial limitation on therapy services is detrimental to Medicare beneficiaries and, through the years, has placed numerous delays on its implementation. In fact, in 2003 when Congress failed to act to extend the moratorium, the Bush Administration used its administrative authority to delay implementation of the caps for nine months – until passage of the *Medicare Modernization Act of 2003*, which further extended the moratorium through 2005. Then when implementing the caps in 2006, Congress also created an almost blanket exceptions process that has done little to control spending.
- **Congress should not expand a flawed payment policy.** The Medicare Payment Advisory Commission, CMS and others believe that there are better alternatives to control the growth in outpatient therapy expenditures, such as making changes to beneficiary cost-sharing, creating specific utilization guidelines, expanding medical review of outlier cases, and/or creating new codes to better bundle therapy services based on diagnoses and treatment rather than time. CMS has an Outpatient Therapy Payment Alternatives project under way and data analysis will begin in early 2012. Expanding an arbitrary and ineffective spending cap to a new setting is not the right policy solution.
- **Capping therapy services in the hospital outpatient setting will reduce the availability of these necessary services to Medicare beneficiaries.** Hospitals are often the health care safety net in their communities. Medicare beneficiaries who require therapy services beyond the therapy cap must have somewhere to go to receive these medically necessary therapy services. Instituting a hard cap on these services in all settings will punish the sickest of Medicare patients and deny them needed care. This is why hospital outpatient departments were excluded from the cap originally, and why they should continue to be excluded.

KEY FACTS

The Balanced Budget Act of 1997 established a $1,500 yearly cap (updated annually for inflation) on outpatient therapy services effective January 1, 1999. In November 1999, Congress passed the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999*, which mandated a two-year moratorium on the $1,500 cap. Subsequent legislation to extend the moratorium, along with an administrative delay, resulted in non-implementation of the cap through December 2005.

While the therapy cap went into effect on January 1, 2006, in February of that year Congress passed the *Deficit Reduction Act of 2006*, which developed an exceptions process for beneficiaries needing coverage above the therapy caps. This therapy caps exceptions process has been extended numerous times in subsequent legislation; most recently in the *Temporary Payroll Tax Cut Continuation Act of 2011*, which extended the exceptions process to February 29, 2012.

For 2012, Medicare beneficiaries can receive up to $1,880 for all outpatient PT and SLP services, and up to $1,880 for all outpatient OT services, unless they qualify for an exception determining that additional services are medically necessary.

The outpatient therapy limits apply when services are provided in medical offices, outpatient rehabilitation facilities/ rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORF), skilled nursing facilities for outpatient or residents who are not in Medicare-certified parts of the facility, and home (from certain therapy providers). Currently, therapy services in hospital outpatient departments are excluded from the cap.

Outpatient therapy spending is distributed over various settings: 35 percent in nursing homes; 29 percent in PT private practice; 15 percent in hospital outpatient departments; 11 percent in outpatient rehabilitation facilities; 5 percent in physician offices; 2 percent in OT private practice, and 2 percent in CORFs.