Rehabilitation Care and the Current Healthcare Environment

An Industry Summary for Rehab Care Providers and Managers

The year 2017 is proving to be another pivotal one for healthcare, most notably continued debate and potential changes to the Affordable Care Act (ACA). Whether the ultimate fate of the ACA is repeal or modification, health delivery is certain to look different in 2018 than it does today. From potential shortages in qualified therapists to incentives and penalties for the cost of care provided, healthcare practitioners and managers must stay abreast of emerging market trends in order remain competitive within their respective areas of patient care.

The following white paper provides a high-level overview of factors that rehab care providers should be monitoring closely in order to stay abreast of emerging policy and to stay competitive in the changing rehab care market place.

The Increasing Burden of Healthcare Costs

For the years 2015-25, health spending is projected to grow at an average rate of 5.8 percent per year. Health expenditures are expected to grow 1.3 percent faster than Gross Domestic Product (GDP) per year over this period; as a result, the health share of GDP is anticipated to rise from 17.5 percent in 2014 to 20.1 percent by 2025.

Specific to post-acute care, the Medicare Payment Advisory Commission (MedPAC) has reported that while spending rates have slowed in recent years, this trend must be considered within a broader context that saw spending on post-acute services nearly double over the past decade. Even given the more recent trend, CMS and MedPAC continue to communicate a stance that there are opportunities to further reduce costs; two prime examples being refinement of patient placement through bundling opportunities and increasing coding accuracy. As a result, regulatory scrutiny across the post-acute continuum is high – and likely to increase.

Comprehensive Care for Joint Replacement – A Harbinger of the Future?

In 2016, for the first time, a new mandatory bundled payment project was initiated. In late 2015, the Centers for Medicare and Medicaid Services (CMS) issued the Comprehensive Care for Joint Replacement (CJR) final rule. The Rule established a mandatory demonstration for a hospital-based, bundled payment for lower extremity joint replacement patients. The demonstration targets a reduction for the 90-day episode of care for Medicare payment after joint replacement surgery. The episode includes all hospital-related care and all post-acute services beginning three days prior to admission through 90 days post-discharge from the hospital.

This demonstration, initiated in 67 Metropolitan Statistical Areas (MSAs), serves as another effort by CMS and its Center for Medicare and Medicaid Innovation (CMMI) to test new value-based payment and delivery models. Although the demonstration project is mandatory only for hospitals within the selected MSAs, hospitals across the country appear to have implemented the bundle. Importantly, this trend has resulted in an overall decrease in joint replacement cases in IRF/ARUs.

Recently, CMS announced that it is delaying expansion of the Comprehensive Care for Joint Replacement, and the implementation of its bundled payment initiatives for cardiac care from July 1 to Oct. 1, 2017. CMS also delayed, for a second time, the effective date of a final rule laying out the implementation of CJR and other bundled payment programs, from March 21 to May 20, 2017.

Furthermore, the agency delayed its Cardiac Rehabilitation Incentive Payment Model and is weighing whether to push back implementation of all bundled payment initiatives even further, until 2018. These programs are mandatory, and different from the voluntary Bundled Payments for Care Improvement initiative, which is not affected by the interim rule.

The Trump administration's move to delay mandatory programs raises questions about the future of government initiatives to usher healthcare out of fee-for-service operations and into a new age of value-based payment, meaning that this is a policy area which must be monitored closely over the coming months.

2017 Medicare Changes – Implications for Rehab Providers

In 2015, following years of advocacy by physicians, physical therapists, and other healthcare professionals, Congress repealed the flawed sustainable growth rate (SGR) formula. A new law, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), established a framework to move Medicare from a largely fee-for-service program to one that bases payment on quality and improved outcomes. In addition, the law extended the therapy cap exceptions until December 31, 2017, and mandated criteria for targeted medical review for certain cases over the $3,700 threshold.

Changes for 2017 regarding fee-schedule payment rates include:

- Effective for services provided on or after January 1, 2017, the 2017 fee schedule conversion factor is 35.8887, which reflects a +0.5% update factor specified under MACRA; a budget neutrality adjustment of –0.013%; a –0.07% non-budget-neutral multiple procedure payment reduction (MPPR) adjustment for imaging services; and an –0.18% target recapture amount.
- The projected impact of other rule changes on outpatient physical therapy services is 0.0% in aggregate. (The actual impact on individual physical therapy practices will depend on the mix of services provided.)

Changes for 2017 regarding the therapy cap include:

- The therapy cap amount for 2017 is $1,980 (up from $1,960) for physical therapy and speech-language pathology combined, with a separate $1,980 cap for occupational therapy.
- Providers may obtain an exception to the therapy cap until the provision for exceptions expires December 31, 2017.

Changes for 2017 regarding the medical review process:

- MACRA extended the targeted manual medical review process, with a $3,700 threshold, through 2017.
- Under this process, CMS determines which therapy services to review by considering specific factors, which include: (1) providers with patterns of aberrant billing practices compared with their peers; (2) providers with a high claims denial percentage or who are less compliant with applicable Medicare program requirements; and (3) newly enrolled providers.
- CMS has contracted with Strategic Health Solutions to serve as the Supplemental Medical Review Contractor (SMRC). The SMRC acts as providers' initial contact point should they receive an ADR. Once information is submitted, the SMRC has 45 days to return a decision. After 45 days, the SMRC will take no further action—although it can turn over a claim to the Medicare Administrative Contractor for further review.

New Evaluation and Reevaluation Codes

- Medicare has implemented eight new CPT codes: three new PT evaluation codes and one re-evaluation code; three new occupational therapy evaluation codes and one new occupational re-evaluation code. These new codes have been added to the list of "always" charges and are covered by Medicare as of January 1, 2017.
- Although Medicare will continue to pay a single value for the tiered evaluation codes, it is imperative that therapists understand how to code patient evaluations correctly.

Medicare Post-Acute Care Reform

Medicare post-acute care reform via the Improving Medicare Post-Acute Care Transformation Act (IMPACT) continues to move forward this year with implementation of new quality measures and data collection requirements across all settings.

Functional Limitation Reporting

Despite changes elsewhere in payment and quality reporting, functional limitation reporting continues without change in 2017.

Labor Supply Challenges – Is a Therapist Shortage on the Horizon?

Physical Therapy

The Bureau of Labor Statistics reports that the demand for physical therapists is expected to increase in coming years. Employment of physical therapists is projected to grow 34 percent from 2014 to 2024, significantly faster than the average for all occupations. As the population ages, physical therapists will increasingly be needed to treat people with mobility issues stemming from chronic conditions, such as diabetes or obesity.

Occupational Therapy

The U.S. Department of Labor's Bureau of Labor Statistics also projects that employment of occupational therapists will increase 27 percent from 2014 to 2024. According to the American Occupational Therapy Association, the demand for occupational therapy services in emerging practice areas such as low vision, caregiver training, driver rehab and safety, home modification and "aging in place" are fueling the need for occupational therapists.

Based on a survey of occupational therapy education program directors, upward of 80% of occupational therapy and occupational therapy assistant graduates were able to secure jobs within six months of graduation – with many graduates securing jobs prior to graduation. Though there is not currently a significant shortage of available professionals nationwide, occupational therapy workforce shortages are appearing in select markets, especially rural areas, and finding highly qualified therapists may become more difficult in the near future.

The Kindred Hospital Rehabilitation Services Difference

Though challenges lie ahead in the rehab industry, opportunities abound as well. To take advantage of these opportunities, providers and managers should closely monitor and adhere to industry changes as they occur. Often, partnerships with leading experts are the most efficient means to leveraging industry trends and avoiding clinical or business pitfalls.

Kindred Hospital Rehabilitation Services places great value on providing industry expertise and strong customer relations in order to be a reliable and trusted business partner for hospitals and health systems. Our goal is to be your strategic partner – keeping you abreast of trends and regulations in the industry and helping you understand how they affect your organization. Every Kindred partnership begins with a discussion and business audit to determine how we can best help achieve your business and therapy goals.

Because each facility is different, our offerings and contracts will be unique as well. From training of therapists to marketing, relationship building, administrative services and denials management – if it's related to rehabilitation, we're the experts you need. Our customized, client-specific approach provides a full range of service options to meet your therapy and business needs.

For more information, click here.

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