



**STATEMENT
FOR THE RECORD
OF THE
NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE
(NASL)**

**BEFORE THE
HOUSE ENERGY & COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
HEARING ON
“EXAMINING BIPARTISAN LEGISLATION TO
IMPROVE THE MEDICARE PROGRAM”**

JULY 20, 2017

The National Association for the Support of Long Term Care (NASL) represents providers and suppliers of ancillary services serving patients in long term and post-acute care (LTPAC) settings. NASL members include rehabilitation therapy companies that employ more than 300,000 physical therapists, occupational therapists, and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in skilled nursing facilities (SNFs) and other long term care settings. NASL members also include providers of clinical laboratory services, portable x-ray/EKG and ultrasound, complex medical equipment and other specialized supplies for the LTPAC sector. Other NASL member develop and distribute health information technology (IT) including full clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers. NASL is proud to be a founding member of the LTPAC Health IT Collaborative, which formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders. NASL is also proud to be a long standing, active member of the Therapy Cap Coalition and fully supports the Coalition’s efforts over the years to work to improve patient access to clinically appropriate Part B therapy services.

NASL is pleased to submit a statement for the record of the Committee’s hearing on “Examining Bipartisan Legislation to Improve the Medicare Program.” The Committee’s focus on Medicare Part B services is of particular interest to NASL as our members deliver these services for America’s

seniors and individuals with disabilities.

NASL thanks Chairman Burgess, Vice Chairman Guthrie and Ranking Member Green for inviting NASL Vice President and Diagnostic Testing Committee Chair Alan Morrison to testify today. We wish to associate ourselves with Mr. Morrison's written statement regarding the clinical laboratory bundling proposal and will focus the remainder of this statement on the Part B therapy benefit.

NASL appreciates the bipartisan support for repeal of the arbitrary Part B therapy caps, which have the potential to negatively affect the lives of many of our most vulnerable citizens. Medicare beneficiaries do not have an effective way to voice their concerns on the arbitrary caps on their care. Our therapists treat patients in the more than 1.5 million patients in nursing facilities and other settings and bring their patient's voice in advocating for their care. NASL thanks Representatives Erik Paulsen (R-MN), Ron Kind (D-WI), Marsha Blackburn (R-TN), and Doris Matsui (D-CA) for championing repeal of the therapy caps by introducing *H.R. 807, Medicare Access to Rehabilitative Services Act*. The Senate companion legislation has been introduced by Senators Ben Cardin (D-MD), Dean Heller (R-NV), Susan Collins (R-ME), and Bob Casey (D-PA). We are encouraged by the leadership that members of this Committee and others in Congress have demonstrated in working on policies that protect beneficiary access to the Part B outpatient therapy benefit, while refraining from undue administrative and regulatory burden on providers.

NASL members treat patients who are most vulnerable to these therapy cap policies as evidenced in CMS claims information and in a data analysis project NASL completed in 2011. Patients relying on the 24-hour and 7-day a week care in the nursing facility are sicker, and most likely to be female. Nursing facility patients are more likely to have chronic conditions including Alzheimer's, chronic kidney disease, COPD and diabetes. Most importantly, our patients are more likely to need therapy above the caps and medical manual review (MMR) threshold.¹ The data analysis indicates that of the SNF patients receiving Part B outpatient therapy, 31% of patients exceeded the PT/SLP cap, while 71% exceeded the OT cap. Additional percentages exceeded the thresholds. The therapy cap policies discriminate against the sickest and those needing therapy the most and it imposes undue burden on both patients and providers. Considering the known research and based on our history of service to the most vulnerable Medicare beneficiaries, ***NASL supports repeal of the arbitrary Part B Therapy Cap. We support replacing the cap with policies that protect beneficiary access to their Part B Outpatient Therapy benefit, allow the continuity of care and that do not impose an undue administrative and regulatory burden on providers. Given the obstacles to repealing the therapy cap, and absent Congress enacting repeal, an extension of the exceptions process is vital to preserve patient access to their medically necessary therapy services. We recognize the exceptions process is not a long-term solution – it is an essential policy floor protecting beneficiaries by assuring access to required therapy services.***

¹ NASL engaged The Moran Company to undertake a data collection and analysis of Part B therapy claims data in 2011.

Background on the Medicare Part B Outpatient Therapy Benefit

Medicare Part B pays for outpatient therapy including the distinct disciplines of physical therapy, occupational therapy and speech language pathology. Physical therapy (PT) restores and maintains physical function and treat or prevent impairments that result from disease, surgery or injury. Occupational therapy (OT) improves and compensates for a patient's ability to conduct activities of daily living, such as dressing, bathing, eating and toileting and the cognitive processes to complete these activities. Speech language pathology (SLP) services help patients with difficulties communicating and or swallowing because of disease, injury or surgery as well as the cognitive requirements of memory, decision-making, language and functional communication.

Outpatient therapy services are covered under Medicare Part B and to receive services, a beneficiary must be referred by a physician or nonphysician practitioner. Medicare regulations and coverage rules require that the beneficiary's medical record include a written plan of treatment with information on diagnosis and therapy goals.

Part B outpatient therapy is provided in many different settings including nursing facilities, hospital outpatient departments, physicians' offices, outpatient rehabilitation facilities, and comprehensive outpatient rehabilitation facilities, as well as by therapists in private practice and home health agencies. Approximately 70% of rehab therapy services are provided in private offices and nursing facilities.² **All settings use the same CPT codes and are subject to the same payment policies – despite patients being treated in these various settings having a wide range of acuity levels and medical needs.**

Because the patients our members treat are often among the sickest with several chronic diseases and comorbidities and most in need of rehabilitative care, they often reach the cap more quickly than those who are living at home and who may receive outpatient therapy in a physician's office. Unlike those who may live independently and speak on their own behalf, many patients we serve have progressive complex conditions that render them unable to provide for themselves and are best treated in this setting. Among those most in need of rehabilitation services are those who required rehabilitation to assure comfort and safety during the end stages of life. Others may be in need of care to assure a safe and functionally independent transition to home. In either case and for any number of those in need of medically necessary rehabilitation to attain a safe and independent discharge from the need for additional Medicare Part B rehabilitation services, we ask that you remove the arbitrary financial cap that can compromise successful completion of the planned care or may increase potential for premature return to the hospital.

² *MedPAC Payment Basics: Outpatient Therapy Services Payment System.*

Retrieved from http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_opt_final.pdf?sfvrsn=0

The Value of Rehabilitative Therapy: Maintenance and or Improvement

The three distinct disciplines of PT, OT and SLP in a program of rehabilitative therapy work to maintain or improve patient's functional abilities for self-care and mobility and work to help patients with their activities of daily living such as dressing, bathing, toileting, transferring (walking and moving), food preparation and self-feeding, problem solving, functional communication and personal safety. These therapies play an important role in assessing and improving cognitive abilities. The Supreme Court recognized the importance of therapy in maintaining function in the recent decision, *Jimmo v. Sebelius* and preventing deterioration of function for patients.

Several years ago, the Centers for Medicare & Medicaid Services (CMS) began an effort to assess and collect data on function for patients receiving Part B outpatient therapy. Providers are required to report functional data in the form of "G-codes" on the claim form as a requirement for reimbursement. CMS requires therapists to choose a test that best matches one of the goals of the patient's therapy and fit the results of that test into CMS' scale of 1-7. CMS has collected the "G-codes" since 2013 and has never released the data. At best, this data is not scientific. It certainly contrasts with the standardized quality data developed as mandated by the *Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)* to be collected by SNFs, IRFs, LTCHs and HHs. Absent scientific data capture and or reports from CMS, our members have undertaken an effort to self-assess the outcome and functional changes in the patients we serve.

History of Therapy Cap Payment Policies

Medicare Therapy Caps took effect in 1999 under the *Balanced Budget Act of 1997 (BBA)*. There are two caps, one cap that limits the dollar amount of PT and SLP services combined to \$1,980³ for 2017. Another cap limits OT services to \$1,980 per person during 2017. In 2006, Congress established an exceptions process that allows an exception to the cap when a patient's condition/medical circumstances warrant additional medically necessary therapy above the caps. The exceptions process requires reauthorization by Congress and Congress has extended it many times since 2006. The current exceptions process expires on December 31, 2017.

Congress imposed an additional therapy cap policy in the *Middle Class Tax Relief and Job Creation Act of 2012*, enacted in February 2012. The *Act* required CMS to conduct manual medical review (MMR) of requests for exceptions for therapy claims over an annual threshold of \$3,700 for OT and \$3,700 for PT and SLP services combined on or after October 1, 2012. A GAO report on the 2012 MMR process was also required.⁴ The GAO report studied the first three months of the program and detailed many problems with the preapproval process.

³ Statute provides for an inflationary increase in the therapy cap amount each year as announced in the annual CMS Physician Fee Schedule.

⁴ *GAO: Medicare Outpatient Therapy, Implementation of the 2012 Manual Medical Review Process*. July 2013. Report to Congress. Retrieved from <http://www.gao.gov/assets/660/655806.pdf>

CMS Institutes Program of Preapproval for Services

CMS implemented the MMR program in September 2012 and it was clear very early that the MACs could not handle the process. Providers submitted requests for preapproval for therapy services above the \$3,700 threshold. Providers were permitted to request up to 20 days of treatment up to 15 days before providing the services above \$3,700. Preapproval requests could only be submitted by U.S. Mail or by facsimile. To expedite the preapproval process, CMS instructed the MACs to review preapproval requests within 10 business days of receipt of all requested documentation to determine whether the services were medically necessary. NASL received multiple reports from providers across the nation that when providers submitted their documentation package to the MACs, often additional documentation requests would come from the MACs before the 10th day effectively stopping the clock on the medical review while the provider mailed or faxed in more documentation. Because much communication was by US mail, there were delays in communication. Also, MACs were not prepared with sufficient number of fax machines to receive the large paper medical records they were requesting from providers. This is especially important to patients in nursing facilities because they cannot wait weeks for approval of the rehab therapy that they need immediately. In fact, a delay in treatment such as those we have described have the potential to reverse progress already achieved.

The GAO report detailed that during the first three months of this preapproval review, MACs were overwhelmed by the volume of what they needed to review, they did not receive guidance from CMS timely to institute it, MACs were unclear how to count the 10-day time frame, the MACs were not prepared for the volume of paper files they had to manage which created a lag time for their response, MACs did not fully automate systems to receive and track preapproval requests in the time allotted. CMS staff estimated that the MACs reviewed more than 167,000 preapproval requests in a three-month period, affecting more than 115,000 Medicare beneficiaries. The GAO report stated, “Both CMS officials and MAC staff acknowledged that the MACs were not able to process all the preapprovals submitted in a timely manner.”⁵

CMS Moves the MMR to Other Contractors

CMS moved the MMR process to the RACs, contractors that ordinarily do not approve services before they are provided and current RAC contracts were utilized. Then, through the *Medicare Access & CHIP Reauthorization Act (MACRA)*, Congress enacted two important changes to therapy cap policies. *MACRA* changed the manual medical review of all claims above the \$3,700 threshold to a system of *targeted* medical review of claims above the \$3,700 threshold. Also, it mandated that entities other than RACs could perform the reviews. Subsequently, CMS contracted with a Supplemental Medical Review Contractor to undertake the reviews. These targeted medical reviews

⁵ *GAO: Medicare Outpatient Therapy, Implementation of the 2012 Manual Medical Review Process*. July 2013. Report to Congress. [GAO-13-613 Outpatient Therapy Manual Reviews](#) page 19.

continue to today. In deciding which services to target for review, CMS may consider services furnished by providers with high claims denial rates, patterns of billing that are aberrant compared with their peers, or other factors.

Lessons Learned:

The Impact of the Preapproval Process on Patients and Providers

The preapproval process/ prior authorization of services that began in 2012 delays necessary care which places patients at risk, decreases patient satisfaction and increases provider cost through inefficiencies. It's a well-meaning system, but using the U.S. Mail and fax machines – experience shows the system as it stands today cannot respond quickly enough for care decisions – especially for the highest acuity patients – that need to be made for patients in nursing facilities. If these patients have to wait several days for therapy to be approved, their functional levels can and will decrease. Consider the cognitively intact and independent patient who has a severe accident. On a fixed income, this person had to be told that the provider was waiting for approval from Medicare to continue treatment. Suddenly, he must decide to remain in the SNF and hope Medicare approves treatment, consider paying for treatment out of dwindling savings or request to be discharged and hope that he can be “safe enough” on his own at home. None of these options are optimal nor should any Medicare beneficiary have to experience this. There is ample evidence that older adults are at risk for further decline in mobility and other activities of daily living, often leading to the need for hospitalization, when therapy services are delayed (and/or interrupted).

During the preapproval process time, it was very confusing for providers and beneficiaries with different MACs using different procedures across the country. Medicare beneficiaries receiving rehab therapy services in nursing facilities such as those who were temporarily disabled but cognitively aware were not aware of the MMR process and continued to be confused regarding what the coverage is and what the processes were.

For example, under MMR, nursing facility patients were progressing to complete a course of therapy treatment only to be told that Medicare hadn't approved continued treatment and providers were waiting for permission to proceed. The patient did not understand that approval is needed once the doctor prescribes the treatment. Instead of focusing on treatment, beneficiaries were anxious over payment for services.

Also, patients who were progressing in their therapy treatment plan and wanted to complete treatment to exit the system and return home found themselves having to increase the overall time in treatment and/or personal costs while waiting to return to the community and improved level of independence.

It is important to consider the special case of patients receiving rehab therapy in facilities such as

skilled nursing facilities, nursing facilities and rehab hospitals. These patients need skilled therapy services at the moment of recognized decline or change in condition. They cannot afford the time to wait for prior authorization and then schedule an evaluation with therapy.

NASL Recommendations

NASL recommends that policies enacted by Congress should build upon the lessons learned from the previous and current medical review programs and consider what is best for patient access and not creating undue provider burden in providing the rehab therapy benefit.

In creating policy, Congress needs to be cognizant that the therapy cap policies it enacts are a one size fits all for the wide range of acuity of patients receiving therapy services in various Part B outpatient settings. Policies that may work for patients in one setting may not work for the patients in other settings, yet patients are subject to the same policies.

NASL recommends that Congress repeal the caps and in their place, enact a targeted program of review of services for medical necessity. NASL members support providing only medically necessary therapy. NASL recommends these Guiding Principles including elements for programs of medical review:

1. Provide for and protect patient access to care and allow for continuity of care
 - a. Allow for special consideration for providers and practices who work with critically complex conditions.
 - b. Maintain beneficiary protections and limitations to preserve beneficiary and provider appeal rights
2. Accountability for providers who consistently over-utilize while minimizing the administrative burden of Medicare audits and reviews
 - a. Continue targeted medical review for those providers who were found to have consistently high utilization and aberrant billing patterns
3. Enhance transparency
 - a. Require that Medicare review contractors provide information to providers who receive denials and mandate GAO assess contractor performance
 - b. Direct the Secretary to make electronic submission of information available within 6 months after enactment
 - c. CMS to report on findings of targeted medical review process
4. Align therapy cap alternative policy with current quality and value-based initiatives
 - a. Exemptions for participation in the merit-based incentive payment system and alternative payment models
5. Align data collection with other efforts already underway such as the IMPACT Act regarding reporting of outcomes.

Given the obstacles to repealing the therapy cap, and absent Congress enacting repeal, an extension of the exceptions process is essential to preserve patient access to necessary therapy services.

NASL opposes prior authorization or preapproval of services because this type of review interferes with the physician/NPP-patient relationship and clinical decision-making, risks access to care, and can result in delayed or incomplete treatment plans, increasing risk for re-admission to the system and higher overall costs. If Congress were to institute a program of prior authorization or preapproval review, NASL recommends:

1. Mandate CMS to create a refined and proven system of pre-approval that can provide timely, *i.e.*, 24-hour responses or no more than 3 days to authorize requests to avoid any delay in care and only when CMS can certify that it has such a process/structure ready, should it be deployed. In setting up such a system, CMS should be required to institute electronic means for providers to submit required documentation along with a system that allows providers to verify that documents were received and the status of the review.
2. Review should be based on clinical best practice and known standards of care, not an arbitrary dollar amount.
3. Provide CMS with adequate funds, technology and resources to be able to manage and promptly address the requests.
4. Beneficiaries as well as providers need to be educated to this Medicare Policy Change, potential costs and timelines.

Conclusion

NASL thanks the Committee for holding the hearing to highlight these important issues. NASL is dedicated to working with the committee and others in Congress to repeal the therapy caps and put in place the right policies that keep the patient at the center and protect beneficiary access to the Part B Outpatient Therapy benefit. We believe new policies should also provide for continuity of care and should not impose an undue administrative and regulatory burden on providers. Absent Congress enacting repeal, we must have an extension of the exceptions process to preserve Medicare beneficiary access to their outpatient therapy benefit.