Statement
On behalf of Genesis HealthCare LLC
Subcommittee on Health, Energy and Commerce Committee
U.S. House of Representatives
Hearing on Medicare Extenders
January 9, 2014

On behalf of Genesis HealthCare, LLC and its subsidiaries, Genesis Rehabilitation Services and Genesis Physician Services, we appreciate this opportunity to provide input to the Subcommittee regarding legislation to extend certain expiring provisions of the Medicare law. Genesis HealthCare LLC (Genesis) is a leading provider of post-acute and long term care services headquartered in Kennett Square, Pennsylvania. Through our rehabilitation and recuperative support programs we facilitate the transitions from acute care and from the skilled nursing setting back to the community.[1]

Our primary focus is with regard to the expiring provisions impacting the delivery of skilled rehabilitation services under Medicare Part B and their impact on our abilities to meet the restorative and recuperative care of post-acute Medicare beneficiary. We urge the committee to expeditiously:

- ***Extend the Medicare Part B therapy exceptions process until Medicare Part B Therapy caps are repealed.*** Section 1103 of the Bipartisan Budget Act of 2013 extends the Medicare Part B therapy cap exceptions process through March 31, 2014. Clinical experiences underscore that the Medicare Part B therapy caps deter medically necessary therapy interventions, shift costs to beneficiaries, increase lengths of stay, and exacerbate re-hospitalization. While we are hopeful that the 113th Congress will address the underlying failures of therapy caps, it is essential that Congress continue the therapy cap exceptions process while efforts move forward to repeal these arbitrary caps. Failure to act expeditiously shifts the costs of medically necessary therapy services

[1] On a daily basis, we meet the health services and shelter needs of nearly 50,000 residents. Assisting us in our care focus is our subsidiaries, Genesis Rehabilitation Services (GRS) and Genesis Physician Services (GPS). The over 15,000 professionals employed by GRS not only meet the needs of the GHC centers, but also provides physical therapy, speech-language pathology and occupational therapy services under contract to 1,600 locations spread across 44 states and the District of Columbia. Annualized, GRS provides rehabilitation services to nearly 400,000 Medicare beneficiaries. Through Genesis Physician Services, we employ over 125 physicians and 175 nurse practitioners and geriatric nurse specialists providing medical direction in our skilled nursing centers and coordinating the involvement of hundreds of attending physicians who have been credentialed to practice in our centers.

to the beneficiary in essence imposing a 100% co-payment on beneficiaries. As we have expressed in previous testimonies, the Medicare Part B therapy cap continues to be one of the most frustrating examples of policy failure. It was bad policy when enacted; it remains bad policy. We applaud Congressmen Gerlach and Becerra and the 150+ co-sponsors of H.R. 713 in their efforts to repeal the arbitrary therapy caps. The essence of geriatric medicine is restoring and/or coping with functional lost. Beneficiaries, care givers and loved ones should not have to choose between walking and talking; the Hobson's choice of current law.

- ***Refocus the medical manual review (MMR) process to secure useful information on utilization patterns; simplify the process and impose realistic requirements for processing of claims so that beneficiary services are not disrupted.*** There are real differences between the populations served under the Medicare Part B outpatient therapy services between institutional and independent practice settings. When Medicare Part B data is arrayed by setting, it becomes very obvious that the MMR process impacts disproportionately on services provided in the institutional setting, especially in the SNF setting. Data developed by a decade of CMS studies affirm an older and more medically complex patient in the institutional setting. Their needs often require a combination of therapies. Their services are delivered under physician order as part of a broader plan of care. While most Medicare Part B patients in the SNF setting have initially received services under Part A, we are experiencing a growth of beneficiaries who either have not broken their spell-of-illness, don't qualify for Part A coverage [3-day prior requirement] and/or have exhausted their Part A coverage.

- ***Mandate the General Accountability Office (GAO) to conduct a congressionally directed study in a reasonable timeframe as a follow-through to the study they previously conducted on how effectively CMS has implemented the MMR process and to secure guidance on whether there is need to differentiate the thresholds between institutional and private practice settings.*** The MMR process is not working. As implemented by CMS it is unfair, dysfunctional and punitive. Requests for additional information have become a horrendous administrative burden, reviews are not being done in a timely manner, overwhelmed CMS contractors are manipulating the process requiring duplicative submissions of information, and CMS is not managing the process.

- ***Review the consequences of the increase of the multiple procedure payment reduction for rehabilitation services (SLP, OT & PT).*** There has been nearly no consideration of the clinical consequences of the multiple procedure payment reduction (MPPR) for rehabilitation services.

> Section 633 of the American Taxpayers Relief Act of 2012 increases the MPPR practice expense reduction to 50% effective April 1, 2013. The reality is that the real impact of the MPPR policy falls on the most frail and vulnerable of Medicare beneficiaries. Over half of nursing home residents receiving Medicare Part B therapy services receive multiple therapies. Indeed, the incidence of this ill designed policy has multiple times the impact on nursing home therapy provision than for the provision of similar services in the independent practice setting. In the institutional setting, rehabilitation interventions are part of the clinical response to help speed a successful transition from the acute to the community setting.

Rehabilitation interventions are cost effective geriatric care with the goal of restoring an individual to his/her former functional status or alternatively to maintain or maximize remaining function in order to help them continue to live as full a life as possible. Decisions made by both Congress and CMS are making it very difficult to deliver medically appropriate therapy services. When you combine the changes made under Part B with the payment revisions being implemented under Medicare Part A for post-acute providers (skilled nursing facilities, rehabilitation hospitals, home health agencies) coupled with the underfunding of rehabilitation services under Medicaid, what emerges is both an undervaluing of the importance of rehabilitation services and a disconnect between commitment and resources.

Skilled nursing centers have become the predominant site for helping restore function and to prevent further deterioration in activities of daily living. Our abilities to successfully transition these beneficiaries from institutional care to home and community based services are highly dependent on physician and non-physician professional services. In our centers, we are offering Medicare beneficiaries comprehensive care at a much lower cost venue than accruing hospital days. Our professional interventions are delivered in an effective and efficient manner that optimize quality, and help reduce the aggregate health system burden of care costs.

We applaud the committee leaders for reaching out for input. We are particularly appreciative of the approach the committees of the House of Representatives are taking with the iterative outreach for input and comments. This approach affords us an opportunity to interact with our medical professionals, those most engaged in direct hands on patient care, soliciting their reactions and providing them with the opportunity to comment on developing changes. These are complex issues, and we look forward to staying engaged in the process, working with individual members and committee staffs to help work through solutions.