National Association for the Support of Long Term Care

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STATEMENT OF THE

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

HEARING ON "THE EXTENDERS POLICIES: WHAT ARE THEY AND HOW SHOULD THEY CONTINUE UNDER A PERMANENT SGR REPEAL LANDSCAPE?"

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY AND COMMERCE

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The National Association for the Support of Long Term Care (NASL) submits this statement to the House Energy and Commerce Subcommittee on Health for its January 9, 2014 hearing on "The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?

NASL is a national trade association representing providers and suppliers of services to long term and post-acute care settings. NASL-member rehabilitation therapy companies contract with nursing facilities and other long term care providers to provide in-house therapy services. NASL member companies employ thousands of speech-language pathologists, physical therapists and occupational therapists—all focused on providing multi-disciplinary therapy to medically complex patients who require therapy provided within the long term and post-acute care spectrum. NASL also represents health information technology developers, suppliers of durable medical equipment, nursing and therapy product equipment, labs, portable x-ray and diagnostic testing services specializing in the long term and post-acute care settings.

NASL also represents providers and other ancillary service providers including health information technology developers, suppliers of durable medical equipment, nursing and therapy product equipment, labs, portable x-ray and diagnostic testing services specializing in the long term and post-acute care settings.

Summary of Statement

NASL strongly believes now is the time to fix the Medicare Part B outpatient therapy cap and the underlying therapy payment system. NASL supports repeal of the arbitrary therapy cap, thereby ending the need for an annual Congressional extension of the therapy cap exceptions process. To achieve this, NASL supports maintaining the current Medicare Part B outpatient therapy cap exceptions process for a period of such time until CMS brings forward the long needed new payment system. Also, the current manual medical review process for claims above $3,700 must be streamlined to make it more uniform and efficient for providers and patients alike.

History of the Medicare Part B Outpatient Therapy Cap

In 1997, the Balanced Budget Act (BBA) created an annual financial cap or limit on physical therapy and speech-language pathology services and a separate cap on occupational therapy for most outpatient settings, beginning in 1999. This cap has put at risk Medicare beneficiaries' access to rehabilitative care that is integral to improving their functional abilities and independence, shortening lengths of acute hospital stay, reducing re-hospitalizations and driving down costs. In response to wide-spread concerns about the impact of the therapy caps on patients, Congress suspended the caps from 2000-2005. In 2006, Congress mandated that the Centers for Medicare & Medicaid Services (CMS) develop an exceptions process for Medicare beneficiaries with certain conditions who require therapy services that would exceed the cap. Congress has continually authorized the exceptions process since that time, and it is currently in effect due to the enactment of the *Pathway for SGR Reform Act of 2013,* which extends the exceptions process through March 31, 2014. Additionally, it prevents a scheduled payment reduction for physicians and other practitioners who are reimbursed under the physician fee schedule (PFS) from taking effect on January 1, 2014 and provides for a 0.5 percent update for such services through March 31, 2014. In total, Congress has overridden the therapy cap policy 11 times since the caps were enacted – to enable the most vulnerable Medicare beneficiaries to receive appropriate and medically necessary therapy as covered under the therapy benefit.

Several years ago, Congress directed CMS to develop an alternative payment system for Part B outpatient therapy. In 2007, CMS established a research project entitled Developing Outpatient Therapy Payment Alternatives (DOTPA). In addition, CMS commissioned the Short Term Alternatives for Therapy Services (STATS) project, and received a final report of short term alternatives in 2010 that included recommendations for pilot testing. The purposes of these projects were to identify, collect and analyze therapy-related data with respect to beneficiary need and the effectiveness of outpatient therapy services. The ultimate goal was to develop

alternate payment methodologies to the current cap on therapy. Despite the extensive time and resources put toward these projects by CMS and many stakeholders, including members of NASL, CMS has still not brought forward potential new reimbursement models.

With the lack of action by CMS, the therapy sector has been working to bring forward models for payment reform. NASL's work with The Moran Company in 2008 tested the feasibility of payment in nursing facility settings based on patient condition. This analysis demonstrated that a prospective payment system based on episodes of care for Medicare Part B therapies is in fact possible. NASL continues to work with The Moran Company to develop alternative approaches based on an episodic payment model, which is both easier for clinicians to manage and more amendable to introduction of quality measures and value-based purchasing mechanisms. Other organizations, including the American Physical Therapy Association and the American Occupational Therapy Association, are pursuing payment changes through coding reform. NASL has provided comments on these reforms. The time has come to bring forward payment models and to test them appropriately.

Status of the Current Extension

The current fee-for-service (FFS) payment system, which dictates annual payment updates based on the Sustainable Growth Rate (SGR), would give physicians and other Medicare practitioners a 3-month 0.5 percent rate increase and extend several Medicare provisions, including the Medicare Part B exceptions process for outpatient therapy services. Unless Congress acts by March 31, 2014, a 24.4 % reduction in physician reimbursements will occur. In addition to physicians, many other practitioners – including Medicare's Part B outpatient rehabilitation therapy providers – who are reimbursed under the Physician Fee Schedule (PFS), will also be impacted.

Part B Outpatient Therapy Benefit

Medicare's Part B outpatient therapy benefit is complicated. Therapy services are delivered in several different settings to a cross-section of beneficiaries who have varying acuity levels and who may require treatment involving any or all three distinct disciplines – physical therapy, occupational therapy, and speech language pathology.

The caps on therapy services discriminate against the oldest, sickest Medicare beneficiaries. The current cap on therapy services stands at $1,920 a year for occupational therapy (OT), and $1,920 for a combination of physical therapy (PT) and speech language pathology (SLP). An estimated 5.6 million beneficiaries received therapy under Medicare Part B in 2010. NASL data analysis by The Moran Company shows that 31% of the Medicare patients who received rehabilitative care in nursing facilities exceeded the PT/SLP cap and 71 percent exceeded the OT cap. In addition, for those nursing facility patients who exceed the caps, an even greater percentage of them exceed the $3,700 threshold triggering manual medical review. We elaborate on this information below.

Profile of the Therapy Patient in a Nursing Facility: Patients in Nursing Facilities Are Older and More Medically Complex

A Medicare beneficiary receiving Part B outpatient therapy in a nursing facility is more likely to be medically complex and has more co-morbidities than patients in non-institutional settings. Nursing facility patients generally are older, and have particular characteristics that come with being older—they often are more frail with greater physical dependencies. The mean age for those receiving therapy in nursing facilities is age 81, with a significant percentage, 45%, who are above age 85.[1] This is in contrast to the patients receiving therapy in private office settings, where the mean age is 71. CMS' data shows that two-thirds of Medicare beneficiaries have multiple chronic conditions and that multiple chronic conditions increase with age.[2] Multiple

[1]See Table 1 "**The Characteristics of Part B Therapy Patients in Nursing Facility and Office Settings are Distinctly Different"** developed by The Moran Company based on an Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates.

[2] See page 10-11. Chronic Conditions Among Medicare Beneficiaries, CMS Chart book: 2012 Edition.

chronic conditions typically affect a patient's response to therapy. These patients have an increased likelihood of dementia or psychiatric illness, and lesser cognitive engagement can result in needing extended time to reach goals. Because patients in nursing facilities need 24 hour, 7-day a week care, they are less independent in general. These patients are more likely to be dually eligible and more likely to be female.

Why Therapy Cap Policies are Detrimental to Nursing Facility Patients: Care Patterns Are Different for Nursing Facility Patients

The co-morbidities, multiple diagnosis and complex medical needs of the beneficiaries in nursing facilities often result in higher levels of care as ordered by their physician. In fact, research undertaken by The Moran Company for NASL vividly shows that a larger proportion of patients receiving therapy in nursing facilities from multiple disciplines reach the therapy caps and thresholds compared to patients receiving therapy from only one discipline. The Moran Company research reached the following key conclusions:[3]

- Beneficiaries receiving therapy from multiple disciplines are significantly older than those receiving only physical therapy.
- Beneficiaries receiving therapy from multiple disciplines are significantly more likely to be poor (dually eligible) than those receiving only physical therapy.
- Beneficiaries receiving therapy from multiple disciplines are significantly more likely to be black.
- Beneficiaries receiving therapy from multiple disciplines are most likely to exceed the cap and manual medical review threshold.

Patients receiving Part B therapy in nursing facilities exceed the caps and thresholds at a higher proportion than those receiving therapy in other settings.

[3]See Table 2 "**Multi-disciplinary Part B Patients Have Different Demographic Characteristics"** developed by The Moran Company based on an Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates.

Did the Patient Receive Therapy in a NF?	Number of patients	% of Total Patients	Number of Patients Hitting the PT/SLP Cap	% of Total Patients who Hit the PT/SLP Cap	Number of Patients Hitting the PT/SLP Medical Review Threshold	% of Total Patients who Hit the PT/SLP Medical Review Threshold	Number of Patients Hitting the OT Cap	% of Total Patients who Hit the OT Cap	Number of Patients Hitting the OT Medical Review Threshold	% of Total Patients who Hit the OT Medical Review Threshold
YES	865,000	16%	282,760	31%	122,360	39%	153,480	71%	56,620	73%
NO	4,653,800	84%	635,100	69%	187,940	61%	62,380	29%	20,640	27%
All Therapy Patients (with known site of services)	5,518,800	100%	917,860	100%	310,300	100%	215,860	100%	77,260	100%

National Estimates based on 5% Standard Analytic Files for 2010

The table above illustrates further the impact of therapy cap payment policies on Medicare beneficiaries receiving therapy in nursing facilities. The chart shows the following:

- More than 5 million Medicare beneficiaries receive Part B outpatient therapy and 16% of those patients receive their therapy in a nursing facility.
- 31% of total patients exceeding the physical therapy/speech language pathology (PT/SLP) cap are in nursing facilities, or roughly double the number of patients overall that exceed the PT/SLP cap.
- 39% of total patients reaching the PT/SLP manual medical review threshold are in nursing facilities.
- 71% of total patients exceeding the occupational therapy (OT) cap are in nursing facilities, which is more than double the percentage of those reaching the OT cap in other settings.
- 73% of total patients reaching the OT manual medical review threshold are in a nursing facility, which is more than double the percentage of those reaching the threshold in other settings.

Clearly, this data shows that nursing facility residents are disproportionately at risk to reach the therapy cap limits and the MMR. Current Part B outpatient therapy policies do not distinguish between beneficiaries who are treated in institutions such as nursing facilities, and thus who are often higher cost cases with co-morbidities and complex medical needs, from other beneficiaries whose needs are very different and much less acute.

NASL Supports Repeal of the Therapy Cap

NASL supports repeal of the arbitrary therapy cap thereby ending the need for an annual Congressional extension of the therapy cap exceptions process. Furthermore, the lack of an adequate payment system has led to Congress imposing the current increasingly confusing hodgepodge one-size-fits-all cost controls including the therapy cap, exceptions process, manual medical review, etc. that are not focused on the needs of the patient. For this reason, NASL supports the development of a new payment system for Part B outpatient therapy that is primarily focused on the patient and reflects such key factors as clinical diagnoses, complexity of rehabilitative treatments and episodes of care. Because the PFS determines payment for Part B outpatient rehabilitation services, it is essential that any modifications to the PFS preserve the ability of outpatient therapy providers to provide the required level of treatment for Medicare beneficiaries. Any modifications to the codes or payment system reform must take into consideration all settings where outpatient therapy is provided.

NASL Supports Streamlining the Current Manual Medical Review Process

The *American Taxpayer Relief Act of 2012* required CMS to conduct a manual medical review (MMR) for beneficiaries whose therapy treatments exceeds a threshold of $3,700 for either OT or for both PT and SLP services. CMS implemented a *prior-authorization process* that approved or denied care prior to its provision. The result was incredible delays of medically necessary treatment for Medicare beneficiaries. Following this rocky start, CMS then implemented a new process where Medicare Administrative Contractors (MACs) conducted *prepayment review* on claims processed between January 1, 2013 to March 31, 2013. CMS then again revised the MMR policy to require the Recovery Auditors (RAs) conduct review for all claims that reach the $3,700 threshold on or after April 1, 2013. Since that time, the Recovery Auditors are conducting two types of review. The first is a *Prepayment Review* which reviews a claim above $3,700 prior to paying the claim. This covers claims submitted by providers located in the Recovery Audit Prepayment Review Demonstration states, which are: Florida, California,

Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri. In these states, the MAC will send an additional documentation request (ADR) to the provider requesting the additional documentation be sent to the Recovery Auditor.

In the remaining states, RAs utilize the other process which is a *Post-payment review*. CMS will grant an exception for all claims with a KX modifier and pay the claim upon receipt. The RAC will then conduct post-payment manual medical review on the claim. According to CMS policy, application of the KX modifier is an attestation by the service provider of the medical necessity of the services being provided to the beneficiary.

While Congress intended for the MMR process to be completed within a ten business day window to avoid disruption of care for the patient, the process implemented by CMS and its contractors has been an administrative nightmare, as reflected in the June 2013 Medicare Payment Commission (MedPAC) report to Congress, and the Government Accountability Office (GAO) study, "Implementation of the 2012 Manual Medical Review Process [GAO-13-613]." GAO found that CMS did not issue sufficient guidance on how to process preapproval requests before the implementation of the MMR process in October 2012, and the MACs that conducted the MMRs were unable to fully automate systems for tracking preapproval requests in the time allotted.

It has been almost a year and a half since the MMR process was implemented in October 2012, and NASL's principal concerns with the MMR process continue to be that providers receive inconsistent and inefficient instructions; they often wait weeks to months beyond the required ten day review window to receive a payment decision; and they often wait even longer to receive payments for services provided. Today, there are unpaid claims that were approved for payment in the Spring of 2013.

NASL Surveys Members on MMR Experience

On December 14, 2013, NASL released survey results regarding the experience of its members with the MMR process. The survey shows that the MMR process ordered by Congress is seldom conducted in the required 10 business days. In fact, the survey shows at least 33 percent of the submitted MMR claims since January 1, 2013 are still waiting processing by Medicare contractors. Furthermore, Congress mandated that the MMR process be conducted over a 10-day time period so as not to disrupt patient therapy. The survey bore out what NASL has been hearing from its members since the inception of the MMR process. For that reason, NASL has joined with a coalition of 20 patient, consumer and provider organizations to urge Congress to retool the MMR system to achieve these goals:

1. Protect beneficiary access from care disruptions by strengthening the ten day MMR requirement.
2. Improve the MMR process by simplification, standardization, and automation of contractor and provider communications.
3. Require a GAO analysis of the MMR process as a follow up to the first report that revealed the problems.

We believe strongly that Congress must insist that CMS enforce a process where the required MMR review be conducted within 10 business days of contractor receipt of the necessary medical documentation, or otherwise be deemed approved. NASL calls on Congress to revisit this issue and insist the MMR process be focused on genuine claims outliers and not cause such disruption to the entire Part B outpatient therapy processing and payment system.

Conclusion

Simply stated, NASL remains convinced that the Part B Outpatient Therapy Cap Exceptions Process should be continued while we work to have the Medicare Part B Therapy Cap repealed. Additionally, CMS has not met the recommended 10-day time frame for the MMR process, or adequately processed claims that have not been submitted since October 2012.

NASL remains committed to working with the House Energy and Commerce Committee to develop a long term solution to modernize Medicare's post-acute care benefit and reimbursement system so that it treats beneficiaries, providers, and taxpayers fairly.

Table 1

The Characteristics of Part B Therapy Patients in Nursing Facility and Office Settings are Distinctly Different

	% of beneficiaries						
Type of setting	NF only	NF + Any Other Setting	Office only	1 other institutional	2 or more other institutional	Office + 1 other	Office + 2 or more other institutional
Mean age (SD)	81.1 (11.1)	78.8 (11.5)	71.1 (10.8)	70.8 (12.5)	72.6 (12.4)	70.9 (11.2)	72.1 (12.6)
Age group							
≤ 55	3%	5%	8%	12%	10%	9%	10%
56-64	5%	6%	9%	9%	8%	9%	8%
65-74	15%	19%	46%	29%	29%	43%	36%
75-84	33%	35%	29%	29%	21%	30%	32%
≥ 85	45%	36%	9%	11%	21%	9%	14%
Sex							
Male	30%	34%	29%	37%	36%	35%	36%
Female	70%	66%	62%	63%	64%	65%	64%
Race							
White	86%	85%	85%	86%	82%	89%	85%
Black	10%	9%	6%	9%	10%	6%	6%
Other/Unknown	4%	6%	6%	5%	7%	4%	8%
Current reason for eligibility							
Old age and survivors insurance	91%	90%	85%	80%	82%	83%	82%
Disability Insurance Benefit (DIB)	8%	9%	15%	19%	17%	17%	17%
ESRD	0%	0%	0%	0%	0%	0%	*
Both ESRD & DIB	0%	0%	0%	0%	0%	0%	*
Dual-eligibility							
Yes	51%	42%	16%	21%	26%	15%	22%
No	49%	58%	84%	79%	74%	85%	78%
Setting							
Urban	75%	77%	83%	74%	79%	80%	84%
Rural	24%	23%	17%	26%	21%	20%	16%
*TOTAL**	*38,028*	*5,222*	*124,354*	*82,767*	*11,573*	*12,190*	*1,896*

** 5,235 beneficiaries with unknown setting*

Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates

Table 2

Multi-disciplinary Part B Patients Have Different Demographic Characteristics

	% of beneficiaries						
	PT only	SP only	OT only	PT + SP	PT + OT	OT + SP	PT + OT + SP
Mean age (SD)	71.5 (11.6)	76.7 (13.3)	72.8 (13.5)	77.6 (12.5)	76.4 (12.7)	79.4 (12.9)	79.0 (11.9)
Age group							
≤ 55	9%	8%	11%	6%	7%	6%	5%
56-64	9%	7%	9%	6%	7%	6%	6%
65-74	42%	23%	33%	23%	25%	16%	19%
75-84	30%	31%	27%	31%	32%	31%	33%
≥ 85	11%	32%	20%	34%	29%	41%	37%
Sex							
Male	36%	42%	33.61	40%	32%	31%	37%
Female	64%	58%	66.39	60%	68%	69%	63%
Race							
White	87%	86%	86%	86%	84%	85%	83%
Black	7%	9%	9%	9%	9%	12%	11%
Other/Unknown	6%	5%	4%	5%	7%	4%	6%
Current reason for eligibility							
Old age and survivors insurance	84%	85%	81%	88%	86%	88%	90%
Disbility Insurance Benefit (DIB)	16%	14%	18%	12%	13%	12%	10%
ESRD	0%	0%	0%	*	0%	*	0%
Both ESRD & DIB	0%	0%	0%	*	0%	*	0%
Dual-eligibility							
Yes	19%	38%	30%	37%	36%	54%	46%
No	81%	62%	71%	63%	64%	46%	54%
Setting							
Urban	79%	76%	78%	80%	80%	76%	80%
Rural	21%	24%	22%	20%	20%	24%	20%
TOTAL*	*188,445*	*11,473*	*15,446*	*5,133*	*27,258*	*2,361*	*10,238*

Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates