BRAIN INJURY ASSOCIATION OF AMERICA

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THE VOICE OF BRAIN INJURY

**Brain Injury Association of America**
**Testimony for the hearing record**
**United States House of Representatives**
**Committee on Energy and Commerce**
**Subcommittee on Health**
***Examining Bipartisan Legislation to Improve the Medicare Program***
**July 20, 2017**

Chairman Burgess, Ranking Member Green, and Members of the Subcommittee:

The Brain Injury Association of America (BIAA) is the nation's oldest and largest brain injury patient advocacy organization advocating for individuals with brain injury and their families since 1980. BIAA has led the effort in Congress to make rehabilitation accessible to individuals with brain injury. BIAA is pleased to submit testimony in regards to the discussion draft *of H.R. _____, to amend title XVII of the Social Security Act to extend the therapy cap exceptions process and manual medical review under the Medicare program.* BIAA strongly supports permanent repeal of the Medicare outpatient therapy caps.

Traumatic brain injury (TBI) is a misdiagnosed, misunderstood, under-funded neurological disease affecting at least 2.5 million children and adults in the U.S. each year. According to the Centers for Disease Control and Prevention, over 5 million individuals live with a disability as a result of a TBI. Depending on type and severity, brain injuries can lead to physical, cognitive, and psychosocial or behavioral impairments ranging from balance and coordination problems to loss of hearing, vision or speech. Fatigue, memory loss, concentration difficulty, anxiety, depression, impulsivity and impaired judgment are also common after brain injury. Even so-

called “mild” injuries can have devastating consequences that require intensive treatment and long-term care. Often called the “silent epidemic,” brain injury affects people in ways that are invisible. The injury can lower performance at school and at work, interfere with personal relationships and bring financial ruin.

For many people with brain injury, rehabilitation is the single most effective treatment to restore function and arrest, reverse or mitigate disease-causative and disease-accelerative processes subsequent to injury. Rehabilitation is provided in a variety of settings, depending on the needs of the individual, including acute care hospitals, inpatient rehabilitation centers, and nonhospital alternative medical delivery settings, such as residential/transitional rehabilitation programs and day treatment programs. Cognitive rehabilitation is a systematically applied set of medical and therapeutic services designed to improve cognitive functioning. Cognitive rehabilitation can play a key role in treatment and management of behavioral, emotional and psychosocial problems including problems of suicide and substance abuse.

Intensive and ongoing rehabilitation care is vital for individuals with brain injury to improve their health status, and in the spirit of the recent *Jimmo v. Sebelius* decision, maintain their functional abilities, and prevent deterioration of function. To demonstrate the importance of rehabilitation, on June 27, 2017, BIAA through our work with the Coalition to Preserve Rehabilitation, along with the Habilitation Benefits (HAB) Coalition and the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition jointly hosted a bipartisan Congressional Briefing entitled *The Value Of Rehabilitation And Habilitation Services And*

*Devices In America's Healthcare System*. The briefing was endorsed and sponsored by BIAA, the only brain injury association to do so, and 60 additional national organizations, attracted over 200 attendees, and included speakers Senator Tammy Duckworth (D-IL) and Representative Glenn Thompson (R-PA). BIAA's Medical Director Emeritus, Gregory J. O'Shanick, MD (President and Medical Director of the Center for Neurorehabilitation Services) was a panelist. The briefing attracted a large number of House and Senate staff interested in the effectiveness of rehabilitation services and devices.

Outpatient rehabilitation therapy is a critical component of an overall rehabilitation plan of care for many Medicare beneficiaries. Rehabilitation helps individuals recover from illness or injury, achieve health and functional status, and live as independently as possible in their homes and communities, rather than in institutionalized settings. For individuals with brain injury, outpatient therapy services are vital to avoiding unnecessary and expensive acute care visits and preventing secondary conditions. It has been estimated that almost 70 percent of Medicare beneficiaries have more than one chronic condition that may require outpatient therapy.

This year marks the anniversary of Medicare outpatient therapy cap implementation. In 1997, as a result of the Balanced Budget Act, Congress capped the benefit for Medicare outpatient rehabilitation services (excluding hospital outpatient services until recently, when the caps were applied to these settings as well). The purpose of this policy was to address alleged over-utilization of the benefit, limit Medicare spending in order to balance the federal budget, and improve the solvency of the Medicare Trust Fund. Congress established one cap of $1,500 for

physical therapy and speech language pathology services combined and another $1,500 cap for occupational therapy services.

Congress delayed implementation of these caps on multiple occasions by placing a moratorium on their enforcement until 2006. The Deficit Reduction Act of 2005 (DRA) implemented the caps but coupled them with a new "exceptions process" to ensure beneficiary access to vital rehabilitation services for those whose treatment needs exceeded the therapy caps. The therapy caps and exceptions process has been extended numerous times to the present day. In 2017, annual inflation adjustments have brought the therapy cap limits to $1,980 for each cap. Outpatient therapy "thresholds" of $3,700 per episode were also established to further limit alleged over-utilization. Once a beneficiary exceeds this threshold, Medicare contractors are permitted to audit providers who submit these claims.

The Medicare outpatient therapy caps are particularly onerous given the recent *Jimmo v. Sebelius* decision. That decision determined that Medicare coverage should available for skilled services to maintain an individual's function, not only to improve it. Pursuant to *Jimmo*, medically-necessary skilled nursing and therapy services (including outpatient therapy) provided by or under the supervision of skilled personnel are covered services by Medicare if the services are needed to improve a beneficiary's condition, maintain the individual's condition, or prevent or slow their decline.

BIAA believes that access to outpatient therapy is essential and that patients need not demonstrate improvement in order for skilled services to be covered as reasonable and necessary. The therapy caps and exceptions process significantly complicate compliance with *Jimmo* for Medicare beneficiaries in need of greater-than-average outpatient skilled therapy. Resolution of the therapy cap issue will help implement full and effective compliance with the *Jimmo* decision.

For years, annual extensions of the therapy caps and exceptions process rode along with the annual legislation to fix the Medicare Sustainable Growth Rate (SGR) formula for physician payment, which was a compelling political issue that Congress invariably passed. Now that the physician fee schedule "fix" has been permanently resolved in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a permanent repeal of the therapy caps is necessary. Whether the caps are repealed permanently or only another short-term fix is possible, the therapy cap fix needs another legislative vehicle. MACRA merely extended the therapy caps exceptions process through December 31, 2017, a necessary but not sufficient step.

If Congress passes no further legislation, the full caps (without the exceptions process) will be imposed beginning in January 2018. Therefore, BIAA strongly urges Congress to resolve the therapy cap issue once and for all before the end of this calendar year.

The current exceptions process provides a relatively effective solution for beneficiaries in need of therapy services that exceed the caps. An extensive list of condition codes determines which

patients can receive therapy beyond the cap, as long as the services can be documented as medically necessary. This is a diagnosis-based system that accommodates most beneficiaries in need, but by definition, leaves some beneficiaries to fend for themselves once the cap applies. Still, the exceptions process is better public policy than an arbitrary cap that cuts off access to therapy services when beneficiaries need them most.

The therapy cap exceptions process is not fiscally sustainable over the long term. There needs to be a more comprehensive solution to this perennial problem. Beneficiaries and providers alike should not be exposed to the uncertainty that accompanies the nearly annual process to suspend imposition of the therapy caps as enacted twenty years ago. That's why ***BIAA urges an outright repeal of the therapy caps.*** That said, if Congress is not able to pass a permanent repeal bill by the end of this calendar year, it must extend the current exceptions process so that Medicare beneficiaries, including individuals with brain injury, who have outpatient therapy needs that exceed the caps continue to have access to rehabilitation therapy services.

BIAA understands that the cost of an outright repeal of the Medicare outpatient therapy caps may need to be mitigated through certain CMS procedures to monitor and grant judicious coverage of outpatient therapy. Some of these mitigation strategies have been debated in the context of Senator Ben Cardin's efforts to help resolve this issue. We address some of these issues below.

BIAA had reservations with last year's Senate language, which sought to employ the use of prior authorization of claims submitted by "aberrant" billers in its efforts to repeal the therapy caps. Our concerns with this proposal focus on the fact that prior authorization has the potential to dilute the authority of rehabilitation professionals to practice rehabilitation medicine and could lead to significant delays in access to patient care.

Additionally, we are concerned that a focus on "aberrant" billers may target specialty therapy practices that focus on high users of therapy services including patients with brain injury. The revised Cardin 2.0 Amendment, currently under discussion in the Senate, does not include prior authorization, which reduces the likelihood of delays in patient access to care and also modifies how "aberrant" billers are defined by accounting for case mix. Both of these provisions are improvements over the original Cardin Amendment.

As already stated, Medicare outpatient therapy caps are arbitrary and are not based on medical necessity. Such caps deny rehabilitative care to vulnerable beneficiaries who need it most, including individuals with brain injury. Additionally, the combined cap of physical therapy and speech-language pathology is problematic as these are distinct clinical services that occur at different times in the continuum of care and address related but separate areas of impairment. For instance, a patient who has a stroke, which is an acquired brain injury, might receive extensive physical therapy to regain mobility but then see the cap limit their ability to obtain services to improve swallowing or the ability to communicate. The choice between walking and

talking is an oft-cited example of the complicating factors and poor public policy surrounding the therapy caps.

Permanently removing the therapy caps is a sound economic decision that will save money for federal taxpayers. Short-sighted denials of additional rehabilitation lead to beneficiaries making partial recoveries or failing to maintain function. This drives up healthcare costs as these patients require more expensive long-term care in settings, such as skilled nursing facilities and nursing homes.

Taxpayers are better served in the long term if Congress invests in lifting the therapy caps and granting access to those in need depending on the severity of their illness or injury. Long-term cost savings will be derived from:

- A reduced need for long-term medical care (e.g., re-admission, nursing care to support daily living, etc.);
- Avoidance of long-term disability; and
- Increased tax revenue from people who are able to return to work.

BIAA has long argued that the Medicare outpatient therapy caps are arbitrary and harm beneficiaries most in need of rehabilitation. BIAA believes that outpatient therapy services should be administered based on medical need, not arbitrary coverage limitations. We wholeheartedly support a permanent repeal of the Medicare outpatient therapy caps and urge this subcommittee to go beyond simply extending the current therapy cap exceptions process.

We thank the subcommittee for its leadership in addressing this critically important policy for Medicare beneficiaries and appreciate the opportunity to submit this written testimony.