AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

American Speech-Language-Hearing Association

Statement for the Record for the
Health Subcommittee of the Energy and Commerce Committee

Examining Bipartisan Legislation to Improve the Medicare Program

I, Gail Richard, President of the American Speech-Language-Hearing Association (ASHA), appreciate the opportunity to provide this statement on two bipartisan issues: 1) the discussion draft pertaining to extending the current exceptions process for outpatient rehabilitation services and 2) H.R. 2465, the Steve Gleason Enduring Voices Act of 2017. We look forward to working with the Committee on both of these issues, which will ensure that Medicare beneficiaries have access to outpatient rehabilitation services as well as access to speech-generating devices.

ASHA is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Our members work in health care settings to evaluate and treat the language, hearing, swallowing, cognition, and communications skills for individuals across the lifespan.

Outpatient Rehabilitation Services

ASHA has been working with the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) on the development of a replacement policy. The principles of the policy are listed below, and we respectfully request the Committee's careful consideration of this proposal.

One possible policy for a permanent fix could include a three-step process of oversight for therapy claims. The first step would be to utilize the current $3,700 threshold as a trigger for post-payment medical review of claims submitted by providers who meet certain criteria. Additional oversight mechanisms could be utilized for those providers on post-payment medical review who are identified as meeting additional factors, in other words, those providers who are not "succeeding" on post-payment review. This oversight, coupled with a pathway for therapy providers to be part of alternative payment models and other performance-based models, will better align therapy services with the transition of Medicare to a value-based system.

For any new proposals presented to the Committee, ASHA respectfully requests the inclusion of the following principles:

1) **Ensuring Patient Access**: Any permanent therapy cap policy should ensure patient access to outpatient therapy services. The fundamental flaw with the current policy is the barrier to care that does not take into account the individual needs of the patient. Additionally, any new policy should ensure that care is not disrupted for long periods of time. In the past, when the Centers for Medicare & Medicaid Services (CMS) has been asked to do a broad review for a large number of claims, they have been unable to efficiently execute the review in a timely manner. As a result, care has been delayed for patients, and high administrative burden has been placed on providers. Not only is

delayed care detrimental for the patient, but it could lead to higher costs to the Medicare program as the beneficiary's progress may regress if care is disrupted.

2) **Developing a Targeted Approach to Oversight of Outpatient Therapy Spending:** ASHA supports a mechanism to ensure appropriate delivery and utilization of outpatient therapy services. This includes targeted reviews of those claims that exceed certain thresholds and are provided by therapy providers that have been identified based on specific factors. Additional scrutiny could be given to providers who continue to have claims rejected under the review process. However, any additional scrutiny, whether through post-payment review or prior-authorization, should include protections for patients and ensure that care is not delayed (see principle #1). This process would be similar to the current $3,700 threshold and post-payment medical review process. Blanket mechanisms, such as the current therapy cap or broad application of prior-authorization across the patient spectrum, are not effective because they restrict patient access, do not take into account medical severity, interrupt the continuity of care, and cannot realistically be implemented by CMS.

3) **Aligning with Value-Based and Performance-Based Models:** We believe that therapy services provided in a qualifying Alternative Payment Model (APM) should be exempt from any permanent outpatient therapy policy. Providers who participate in APMs would already be subject to quality and outcome requirements, as well as a shared risk for the cost of care, which would ensure efficient provision of services. In addition, while therapy providers are not currently part of the Merit-Based Incentive Payment System (MIPS), we anticipate that these providers will be added to the program in 2019. MIPS provides performance-based penalties and payment adjustments to providers. Under MIPS, the therapy cap and ongoing short-term fixes could impede the ability of providers to maximize outcomes, decrease costs, and improve performance. A permanent fix is essential in order for therapy providers to effectively participate in MIPS.

<u>Therapy Cap Overview</u>

For the past 20 years, since the inception of the therapy cap under Balanced Budget Act of 1997, Congress has acted 16 times to avoid implementation of the cap in order to avoid the devastating impact on the rehabilitation needs of Medicare beneficiaries. Continuing discussions on the possibility of extending the current therapy cap exceptions process would be a missed opportunity to permanently resolve this perennial issue that drains time and resources on a policy provision that is opposed by the overwhelming majority of the members of Congress. Each extension of the exceptions process diverts resources away from the need to permanently replace the cap and implement strategies that would improve the integrity of the Medicare program while ensuring that its beneficiaries retain access to the care they require.

We recognize that there are many competing issues that require the attention of the Committee, but none have plagued Congress and Medicare beneficiaries for as long as the therapy cap. The legislation has received a majority of cosponsors within both the House and Senate over the past several Congresses and currently has the bipartisan support of 177 members of the House, including 46 original cosponsors.

Impact on Beneficiaries

Patients with medically complex conditions and comorbidities are far more likely to exceed the cap than beneficiaries with a single distinct illness, injury, or condition (with certain exceptions). Of those requiring care beyond the 2017 level of the therapy cap, which is $1,980, are some of the most vulnerable and medically complex beneficiaries covered by Medicare. Most negatively and unfairly impacted are those beneficiaries who require both speech-language pathology and physical therapy services within the same year. The combined cap on speech-language pathology and physical therapy (PT) services forces the beneficiary with the unenviable dilemma of choosing between communicating (talking), independent feeding, and swallowing OR essential physical activities (walking) associated with daily living. While the exceptions process allows for medically necessary care beyond the cap, the impermanency of the policy places a high level of stress on consumers who know they rely on rehabilitative services to maintain their daily function and extend their lives.

Cost Containment

Provisions imposed through various versions of the exceptions process, including targeted manual medical review, have proven successful at providing cost containment while maintaining some level of access to Medicare beneficiaries. However, the burden on providers and Medicare contractors alike is over-whelming and unnecessary. Furthermore, Medicare beneficiaries are dealing with the insecurity of whether or not their essential rehabilitative care will continue to be covered. The arbitrary application of reviews do not fully take into account available data to help both providers and CMS identify the areas of most significant concern regarding potential and perceived over-utilization. Even with such inefficiencies under the current review process, between the years of 2011 and 2015, per beneficiary spending has been reduced by nearly 8% across rehabilitation disciplines (Moran Corporation). **In fact, total spending on speech-language pathology services was reduced by 7% from 2011 to 2015, even though the percentage of Medicare beneficiaries seeking speech-language pathology services expanded by 14%.** This data provides direct evidence that targeted medical review can successfully contain cost and ensure that services are provided based on medical necessity. **Elimination of the cap and replacing it with a modernized utilization threshold would ensure continued integrity of the Medicare program and appropriate access to care for beneficiaries.**

Modernization of the Rehabilitation Benefit

The current therapy cap exceptions process was established and implemented under the traditional fee-for-service program related to the Sustainable Growth Rate. ASHA urges the Committee to revise any new aspects of utilization control for therapy services so that they are in alignment with the principles established by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (P.L. 114-40) and implemented under the Quality Payment Program (QPP). Under the QPP, the Medicare program is moving away from fee-for-service and provides for the expansion of APMs, which would emphasize outcomes and shared risk financing to help ensure program integrity and quality. In addition, the MIPS includes required categories of reporting that also ensure program integrity by focusing on quality reporting, advancing care information, and improving clinical practice activities and resource use data in order to modify provider payments and incentivize improvement, efficiency, and quality.

Upon repeal of the therapy cap, all outpatient services should be subject to the provisions of MACRA; thereby, enhancing the importance of quality, efficiency, and outcomes. Utilization of therapy services under APMs would be scrutinized based upon value to the patient in achieving desired functional outcomes and avoiding unnecessary procedures or re-hospitalizations. An example would be the provision of speech-language pathology dysphagia evaluation and treatment to ensure patients did not aspirate or remain on feeding tubes longer than medically necessary. Under MIPS, therapy payments would be modified based on quality and resource use, which directly incentivizes providers for efficiency and best practices.

In addition, provider scores would be publicly available, which would continue to work with the clinical improvement activities and advancing care information categories to further incentivize improvement. **Under the QPP, every dollar of therapy spending would be subject to review and payment modification based upon, quality, efficiency, and outcomes.** In regard to therapy services, any additional utilization controls contemplated by Congress should consider the impact of the QPP provisions and more narrowly target outliers. Such an approach would better address CMS's limited resources and focus on providers who are already demonstrating a certain level of difficulty in complying with the QPP activities.

H.R. 2465, the Steve Gleason Enduring Voices Act of 2017

The Steve Gleason Act of 2015 removed speech-generating devices (SGD) from capped-rental requirements for durable medical equipment under Medicare for three years. Capped-rental requires the patient to rent an SGD over a 13-month period before owning a device. Prior to the legislation, in accordance with Medicare rules, if an SGD user resided in a nursing home, hospice, or hospital, Medicare payment for the SGD stopped. Many of these facilities did not and could not supply beneficiaries with a uniquely configured SGD substitute. Ongoing and permanent access to Medicare coverage of SGDs will ensure individuals who medically qualify for an SGD to continue to use their personalized devices. The Steve Gleason Act of 2015 is expected to expire on October 1, 2018. It is imperative to make this law permanent so that individuals in need of these customized devices will continue to have access to them.

<u>Speech-Generating Devices (SGDs)</u>
SGDs are highly customized electronic augmentative and alternative communication (AAC) devices, which are used to supplement or replace speech, enabling individuals with functional communication impairments to verbally communicate their needs. Patients that require SGDs are those with medically complex conditions, including those with unstable progressive and degenerative diseases. The largest population requiring SGDs are patients with neurodegenerative diseases (e.g., ALS, or amyotrophic lateral sclerosis, Parkinson's disease, multiple sclerosis), conditions where cognitive function and the need for communication remains intact, but the physiological ability to speak diminishes. SGDs are the only effective communication means for these patients, offering greater control of their health and their lives. SGDs are durable and customizable medically-purposed technologies that allow the speech-language pathologist, caregiver, and patient to modify the vocabulary, language, and accessibility options to meet the unique and changing needs of the patient and family.

Data are not available to determine the average length of use for the SGDs because it is a device that is almost exclusively purchased for individual use. There would not be a cost-advantage for rental over purchase of the device because SGDs are used long-term. The treatment and medical care advances that have resulted in an increased life expectancy for the general American population are also prolonging the lives of patients with neurodegenerative disease. The National Institute of Neurological Disorders and Stroke reports the average age of onset of Parkinson's is 60-years-old, but states that with medications most people can live productive lives for many years after diagnosis. Thus, the expectation of increased longevity for these populations also supports the long-term use of the SGD and the importance of purchase rather than rental.

As rental units, SGDs cannot be readily substituted because they require a high level of customization. Under the current Medicare rules, substitution of the rented unit would need to be arranged upon admission to a hospital, skilled nursing facility (SNF), or hospice because monthly Medicare payments to the durable medical equipment supplier are terminated during institutionalization. Institutions and facilities do not have ready access to SGDs and are not funded to supply the device. When purchased, the patient has the ability to bring in their personalized device and continue the method of effective communication that they have mastered prior to the inpatient stay. The patient's need for an alternative communication device is most critical in an institutionalized setting because of the need for effective communication with health care staff.

If a rented SGD were to be returned to the vendor upon admission, the vendor would need to delete all customized and personalized information, including customized vocabulary. Vendors would not be able to retain copies of the vocabulary (e.g., download the personalized information), store it, and then reload it when the next rental period went into effect. Because of the rental reimbursement rules and equipment liability issues, it would not be possible for the manufacturers to support the SGD without reimbursement. These rules, which are meant to protect the Medicare program from misuse, inadvertently place the most fragile Medicare patients in a vulnerable situation, leaving them without the ability to effectively communicate their needs.

It is predictable that the impact of bundled rental payment would negatively impact many small businesses, limit options, and create access issues in this very specialized industry. The SGDs are only available from four to five major manufacturers, with a few smaller companies that primarily provide accessories. Because the overall utilization is relatively low when compared to other medical devices, there are very few SGD suppliers. Delivery is not a regularly scheduled event to the patient's home, such as with oxygen or diabetic supplies, and repairs or replacements often require shipping and time. The rental program, along with the ever-increasing requirements and cost, places SGD suppliers at risk of losing financial viability. In addition, accessories (e.g., mounts, switches) are sometimes supplied by a different manufacturer who may not provide these accessories for rentals.

The loss of options for obtaining and servicing SGDs, along with the precarious issues related to the inpatient stay, has the potential to leave patients with neurodegenerative diseases without an essential means of communication, particularly at their most medically vulnerable times.

Once the Steve Gleason Act of 2015 expires, patients who enter an inpatient facility will be stripped of their personalized rented SGD because of the capped-rental policy. This action will limit the ability of the speech-language pathologist to provide communication options for critical situations, including health care decisions and end-of-life scenarios. For these patients, there are communication needs that are extremely personal and privacy issues arise in the process of returning the device. When the device is personally owned, it allows the speech-language pathologist to include the most intimate and private details the patient needs to communicate with medical professionals and family. Finally, the negative impact of not being able to effectively communicate with all caregivers cannot be underestimated. **ASHA urges the Committee to remove Medicare's capped-rental requirement on durable medical equipment, specifically SGDs.**

Conclusion

Thank you for the opportunity to provide this statement for the record. ASHA looks forward to continuing to work with the Committee and Congress to find permanent solutions to both the therapy caps and access to SGDs. For more information, contact Ingrida Lusis, ASHA's director of federal and political advocacy, at 202-624-5951 or ilusis@asha.org.