



September 30, 2011

The Honorable Wally Herger, Chairman
The Honorable Pete Stark, Ranking Member
Subcommittee on Health
Committee on Ways and Means
U. S. House of Representatives
Washington, D.C. 20515

Chairman Herger and Ranking Member Stark:

The National Association for the Support of Long Term Care (NASL) is pleased to submit for the record a statement regarding the Health Subcommittee's hearing on September 21, 2011, regarding Expiring Medicare Provider Payment Policies. We commend the subcommittee for addressing these critical issues, and we would like to call particular attention to the need to resolve the long-standing issue of the Medicare therapy cap.

NASL is a trade association representing providers of both ancillary services and products to the long term and post acute care sectors. Our member companies provide speech-language pathology; physical and occupational therapy; portable X-ray/EKG and ultrasound; pharmacy; long term and post acute care (LTC/PAC) information technology systems; and other ancillary services. NASL members also provide products such as complex medical equipment; parenteral and enteral supplies, equipment and nutrients; and additional specialized supplies for post-acute care settings nationally.

History of the Therapy Cap

The therapy cap policy was authorized as part of the Balanced Budget Act of 1997, when an annual financial limit of \$1,500 on physical therapy and speech-language pathology services, and a separate \$1,500 cap on occupational therapy services were established. The therapy cap was intended to be a temporary policy until the Centers for Medicare and Medicaid Services (CMS) could develop an alternative payment methodology for therapy services for congressional consideration.

Congress has acted numerous times to forestall the effect of the therapy cap policy on seniors and people with disabilities under the Medicare program. This was first accomplished through a series of moratoria on the implementation of the cap, and later through a broad-based exceptions process. Congress took these actions because from the very beginning, there was wide recognition that a cap on therapy services was poor public policy.

National Association for the Support of Long Term Care
1321 Duke Street • Suite 304 • Alexandria, Virginia 22314-3563
(703) 549-8500 • FAX (703) 549-8342 • www.nasl.org

Flaws in the therapy cap policy are well chronicled, and they include the following concerns:

- Sets an arbitrary dollar limit on therapy services without regard to patient need
- Not tied to clinical indicators or standards of care for therapy conditions
- Overrides the therapist's clinical decision-making and disrupt plans of care
- Hinders quality outcomes and threatens quality of care for individuals with therapy needs above the cap amount
- Not an effective control on utilization, and does not address all segments of growth in therapy services

Impact of Therapy Cap Policy

In January 2012, the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process. NASL believes that the exceptions process must be extended to avoid unduly affecting those beneficiaries who are most in need.

An arbitrary cap on therapy services without regard to the clinical appropriateness of care discriminates against the most vulnerable of our Medicare beneficiaries. Beneficiaries who experience stroke, neuromuscular diseases, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be harmed by this arbitrary limitation on services.

The therapy cap reduces access to rehabilitation services for Medicare beneficiaries by limiting their choice of providers, forcing them to bear 100 percent of the cost of their care once they exceed it, or self-rationing their care to avoid exhausting their benefits. The therapy cap shifts costs, delays care, and reduces an individual's ability to remain independent in their community.

The arbitrary cap also prevents beneficiaries from receiving the rehabilitation care they need in a timely fashion. Beneficiaries who fail to receive the rehabilitation care they need from a physical therapist, occupational therapist, or speech-language pathologist are more likely to require higher-cost interventions to remain functional. The harmful effect of the cap is worsened by coupling physical therapy and speech-language pathology services under a single cap.

In 2006, Congress allowed the therapy caps to go into effect but authorized Medicare to allow exceptions for beneficiaries needing additional rehabilitation services based on diagnosis, clinician evaluation and judgment. Congress has acted a number of times to extend the exceptions process for beneficiaries, but the exception is authorized only through December 31, 2011.

Extend the Therapy Caps Exceptions Process

This is a propitious time for the Subcommittee on Health to review the therapy cap exceptions process. The process has been in place for nearly six years, and the nearly annual specter of arbitrary limits being imposed on the provision of therapy services continues to cause distress for Medicare beneficiaries and their families, as well as being a source of regulatory uncertainty and concern for therapy providers. Congressional efforts to extend the exceptions process have protected beneficiary access to rehabilitation care, but the uncertain nature of the legislative process has led to a number of interruptions in the continuity of care to Medicare patients.

The problem flared again last year when therapy caps were imposed in January and February while Congress debated Medicare legislation. Thousands of Medicare beneficiaries suffered disruption in their treatment programs because they had reached their therapy cap limits. The therapy cap is a particularly harsh policy for nursing home residents. Our members saw many of their patients curtail therapy treatments when they hit the arbitrary caps, and the progress they had achieved in restoring their functional status often was lost. This disruption in the continuity of care added to the cost of future treatments, and it caused anguish for patients that suspended their rehabilitative care.

The near-term policy priority for Congress should be to maintain coverage of medically necessary therapy services for Medicare beneficiaries. We recommend that the therapy cap exceptions process be extended until a new payment system is put into place to ensure that Medicare beneficiaries needing therapy services will receive those services without delay, or unfair financial burden. The exceptions process is a necessary safety net for many Medicare beneficiaries.

Principles for an Alternative Payment System for Therapy Services

NASL members recognize that we need a new payment system for therapy services that better aligns beneficiary needs with the services delivered. We are eager to work with Congress and CMS to develop a condition-based payment system as an alternative to the therapy cap. NASL members have been active participants in two recent CMS sponsored projects – the Short Term Alternatives for Therapy Services (STATS) project, and the Development of Outpatient Therapy Alternatives (DOTPA) project

NASL also sponsored a research project in 2008 that was conducted by The Moran Company to develop a proposal for an alternative therapy payment system. The project used 2004-2006 billing data for more than 200,000 patients receiving Part B therapy services in SNF settings. NASL has briefed CMS on the study and provided the agency with copies of the study. Key features of the NASL's proposed payment system would include the following items:

- **Providers would be paid based on an “episode of care” (EOC)** which is defined as all care provided by therapy disciplines in one site of care without a break of 60 days or more (no therapy services billed during that time) and without a discharge from and readmission to a SNF.
- **The EOC would be mapped to relevant clinical characteristics that influence the cost of therapy** using a combination of ICD-9 diagnosis codes and condition codes that CMS may develop to include in the claims.
- **Providers would be paid for short-term outlier cases.** We found that patients were seen by one or more therapy disciplines over a day or two with no further treatment. These appear to be cases in which patients were being evaluated or where therapy was started and immediately discontinued for various reasons. These cases have consistent cost profiles that support a flat outlier payment. This payment could be set either per therapy discipline, or by bundling disciplines in the SNF setting and provide an outlier payment for one, two, or three disciplines or for each combination.
- **Providers could request exceptions for unusually high cost, complex cases.** For a small number of complex cases, the provider should be able to request an exception based on medical necessity. The payment would be triggered by a defined point beyond the average length of episode of care (e.g., two standard deviations), at which time payment would be based on a weekly rate based on the mean cost per week that decreases each week by a fixed percent for some limited number of weeks. The mean cost per week may be set in the SNF based on one, two, or three treating disciplines, or by specific combination of disciplines, and may be set by specific discipline separately in outpatient settings.
- **Weights could be set for the EOCs based on mean costs.** The mean costs for EOCs that map to different condition groupings can be determined with or without comorbidities and other payment adjustor variables. We would include short-term outlier EOCs in the weight setting, as they appear to have a relatively predictable volume and cost. Comorbidities and other payment adjustment variables can be either incorporated into weights directly or assigned a separate percentage of the budget to be allocated as add-on payments. The weights are multiplied by a conversion factor set by CMS to allow for budget neutrality.
- **When care is interrupted by a change in health condition or other circumstance outside the provider’s control, a partial payment adjustment mechanism would be provided.** For example, payment is pro-rated based on the mean length of episode for the applicable EOC.

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- **Payments would be geographically adjusted using an appropriate wage index.**
- **Provision would be made for annual updates based upon selected economic indicators.**

Identification of these principles is an important step toward developing a new payment system that would ensure that beneficiaries receive the high quality, comprehensive therapy services they deserve, and that Medicare pays for value-driven services. We look forward to continuing this dialogue with you to ensure that Medicare patients continue to receive medically necessary therapy services without delay, or undue financial burden. We applaud your leadership on this issue, and NASL would be pleased to work with you to develop an alternative payment system.

Thank you for the opportunity to offer these comments on behalf of millions of frail, elderly, and disabled Americans we provide services to each day.

Please feel free to contact me by telephone at (703) 549-8500, or by e-mail at cynthia@nasl.org with any questions that you may have regarding these comments.

Sincerely,



Cynthia K. Morton
Executive Vice President