Statement for the Record

For the Hearing on
“Examining Bipartisan Legislation to Improve the Medicare Program.”

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

July 20, 2017
Introduction
The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) represents over 13,500 non-profit and proprietary skilled nursing facilities (SNFs), assisted living residences (ALRs), and homes for individuals with intellectual and developmental disabilities. With such a membership base, the Association represents most SNFs and a rapidly growing number of ALRs. We appreciate the opportunity to offer a Statement for the Record to your hearing entitled “Examining Bipartisan Legislation to improve the Medicare Program.”

Statement on Discussion Draft Related to Therapy Caps
SNFs commonly provide Part B therapy to residents who do not otherwise qualify for Part A SNF benefits (such as not having a qualifying 3-day hospital stay or exhausted Part A benefits), or to non-residents (such as residents in an adjoining ALR or senior living apartment). In 2015, nearly 900,000 Medicare beneficiaries received Part B therapy services from a SNF provider.

We believe that the Medicare Part B therapy caps, established by the Balanced Budget Act of 1997 (BBA) under the premise of cost-containment have outlived their expected usefulness. These caps have been historically problematic, create a cloud of uncertainty, and create a barrier to the success of recent broader patient-centered quality initiatives and value-based payment (VBP) models.

Under current policies, Part B therapy payments to SNF decreased 3.8%, from $2.26 billion in 2012 to $2.17 billion in 2015, which correlates with a 2.6% decline in per-beneficiary payments. This validates that more restrictive policies are unnecessary to control growth.

AHCA/NCAL appreciates that the Congress has previously responded to providers and beneficiaries, and has mitigated many therapy cap beneficiary access concerns by extending a cap exceptions process on numerous occasions, and is proposing to do so again with this discussion draft bill. We applaud your attention to addressing this important issue by considering another extension to the current exceptions process policy, which would at least protect the status-quo. However, we ask that the Health Committee consider whether the time is right to consider developing a permanent solution to repeal the therapy caps. We believe that a permanent solution should:

- Ensure timely and uninterrupted beneficiary access to outpatient therapy,
- Build upon the program integrity success of the current targeted review program established by the MACRA provisions,
- Align outpatient therapy data collection efforts with IMPACT Act provisions, and
- Align outpatient therapy policy with various person-centered value-based payment models.

Background
Outpatient therapy services are primarily furnished by physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs). Medicare also covers outpatient therapy services furnished by physicians, and non-physician practitioners (physician assistants, clinical nurse specialists, and nurse practitioners as permissible by state law). These services may be furnished in an office, facility, or in the beneficiary’s residence.
The Medicare Part B outpatient therapy benefit covers skilled services for individuals to restore function, such as ability to walk, to dress oneself, or to feed oneself related to a medical condition, or to maintain or delay decline in function for individuals with chronic progressive conditions.

We note that, while a specific medical diagnosis is important, research has demonstrated that a person’s ability to function safely in their home environment, rather than the diagnosis per se, is frequently the determining factor in whether an individual 1) is able to remain at home, 2) will require costly inpatient healthcare in order to restore health and function, or 3) will require long-term care in an alternative living environment (e.g. nursing facilities, assisted living centers, etc.). For those needing long-term care, function is critical to maintaining health and quality of life.

Additionally, much research has demonstrated that outpatient therapy services are an effective lower-cost option for Medicare beneficiaries to prevent surgeries and hospital admissions or readmissions, and to safely complete recovery of function after an outpatient surgery or a hospital, or post-acute care (PAC) stay in a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), or from a home health agency (HHA).

In fact, a common component of recent Medicare fee-for-service VBP initiatives is that outpatient therapy services are included in the episode window for quality and resource use outcomes that upstream physicians, hospitals, and PAC providers are held accountable to. This is a significant environmental change from when the therapy caps were enacted twenty years ago. At that time, the only systemic utilization and quality controls on outpatient therapy were the physician certification requirement, and the various Medicare medical review programs. Today, all key providers along the beneficiary’s continuum of care are being held accountable for the cost and quality outcomes associated with outpatient therapy services.

Specifically, under recently implemented and emerging Medicare fee-for-service (FFS) VBP models that emphasize; 1) quality measurement, 2) care-coordination across all care settings, and 3) cost-containment across a beneficiary’s episode of care, incentives have been created for physicians, hospitals, and PAC providers to seek alternatives prior to hospital admissions or readmissions, and if admitted, to transition care to effective but lower-cost care in an expedited but safe manner. Examples of recent Medicare models and initiatives that incentivize the use of lower-cost outpatient therapy services are summarized in the Appendix attached to this testimony.

In conclusion, thank you again for the opportunity to submit a written statement today. We look forward to answering any questions you might have and to working with you to create a modern patient-centered Medicare outpatient therapy benefit.

Sincerely,

Mark Parkinson
President and CEO
AHCA/NCAL
Appendix: Recent Medicare Initiatives Incentivizing Cost-Effective Outpatient Therapy

**March 2010** – The Affordable Care Act established several new programs that incentivize the use of lower-cost approaches to care, including outpatient therapy services.

- The Inpatient Hospital VBP program in Section 3001(a) of the ACA required CMS to develop quality and resource use measures for an episode of care, which includes the hospital stay plus all related services during a 30-day period after discharge.

- The Bundled Payments for Care Improvement (BPCI) initiative was developed by the Center for Medicare and Medicaid Innovation (Innovation Center).
  - In Model 2, the episode of care includes a Medicare beneficiary’s inpatient stay in the acute care hospital, post-acute care, and all related services during the episode of care, which ends either 30, 60, or 90 days after hospital discharge.
  - In Model 3, the episode of care is triggered by a Medicare beneficiary’s acute care hospital stay and begins at initiation of post-acute care services with a participating LTCH, IRF, SNF or HHA. The related services included in the episode of care ends 30, 60, or 90 days after the initiation of the episode of care.

- Various CMS Accountable Care Organization (ACO) initiatives were developed by the Innovation Center. ACOs are groups of doctors, hospitals, and other health care providers (including outpatient therapy providers), who come together voluntarily to give coordinated high quality care to their Medicare patients throughout the year rather than just during a discrete acute episode. The ACO model encourages coordination of care throughout a beneficiary’s life to preserve overall health and function rather than just the stabilization and recovery from discrete acute health events.

**April 2014** – Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) established the SNF VBP program which requires SNFs to be held accountable measure performance based on hospital readmission, including related services furnished the 30 days after discharge from the SNF.

**October 2014** – The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) established requirements for CMS to develop and implement standardized cross-setting post-acute provider (PAC) quality and resource use measures to evaluate and compare provider performance in quality and cost of care across an episode of care. These measures include costs and functional outcomes attributed to related services furnished during a 30-day period after discharge from a PAC provider.

**January 2015** – The Secretary of Health and Human Services established a goal of having 50% of Medicare fee-for-service payments be under patient-centered alternative payment models and 90% of these services be linked to quality measures by the end of 2018. The outpatient therapy service benefit does not currently meet the requirement of either initiative, but we recommend modernized and aligned outpatient therapy data collection and payment policies be enacted that would achieve these objectives.

**April 2015** – Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established Physician Fee Schedule reforms and requires physicians and office-based providers to choose to participate in Advanced Alternative Payment Models (APMs) or the Merit-based Incentive Payment Systems (MIPS) to earn updates by 2020. APMs and MIPS incorporate quality and resource use measures. Outpatient therapy providers are not eligible to participate in the APMs/MIPS incentive programs till at least 2021. At that point, only outpatient therapy providers in private practice would be considered for participation. In contract, facility-based outpatient therapy providers (e.g. SNFs, HHAs, outpatient rehabilitation facilities (ORFs), and...
comprehensive outpatient rehabilitation facilities (CORFs), that represent nearly two-thirds of outpatient therapy utilization are currently excluded from any potential opportunity to participate in the APMs and MIPS programs. Functional data reporting standardization provisions would need to be enacted to provide the data necessary to enable outpatient therapy providers in all settings to participate in the MACRA developed APM and MIPS VBP programs.

**March 2016** – CDC Guidelines for Prescribing Opioids for Chronic Pain includes evidence and recommendations that nonpharmacologic treatments, including physical therapy, are preferred to opiate therapies produce more effective pain and function outcomes, are associated with lower median annual costs, and provide lower health risks.

**April 2016** – CMS implemented regulations regarding the Comprehensive Care for Joint Replacement (CJR) Model. Authorized under section 1115A of the Social Security Act, acute care hospitals in selected geographic locations receive retrospective bundled payments for episodes of care for lower extremity joint replacement or reattachment of a lower extremity. The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers (including outpatient therapy providers). The episode of care continues for 90 days following discharge. Note – AHCA/NCAL support voluntary rather than mandatory participation in such demonstration model(s) until such time that the model(s) prove successful at maintaining/improving care while controlling costs.

**May 2017** – CMS finalizes regulations to implement the Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR), effective January 1, 2018. Authorized under section 1115A of the Social Security Act, acute care hospitals in selected geographic locations receive retrospective bundled payments for episodes of care for two new cardiac EPMs, the acute myocardial infarction (AMI) EPM and the coronary artery bypass graft (CABG) EPM, an orthopedic surgical hip/femur fracture treatment (SHFFT) EPM, and technical changes to the previously implemented CJR EPM. These models model hold participant hospitals financially accountable for the quality and cost of a the EPM episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers (including outpatient therapy providers). The episode of care continues for 90 days following discharge. Note – AHCA/NCAL support voluntary rather than mandatory participation in such demonstration model(s) until such time that the model(s) prove successful at maintaining/improving care while controlling costs.