and greatly detract from the provision of the therapy provided to Medicare beneficiaries. Every requirement that does not absolutely contribute to quality care should be eliminated.

We strongly believe in provider accountability, and we support in concept payment incentives for the provision of quality care and penalties for the provision of sub-standard care. We do not support, however, burdensome rules and restrictions that are not patient-centered but which instead add to the costs of providers doing business with the Medicare program. In short, we believe that all regulations and other administrative requirements should be measured by the simple yardstick of whether they add value associated with the treatment and outcomes for the Medicare beneficiary.

In an earlier section of this letter, we discussed the Medicare Part B payment issues that affect the provision of outpatient therapies. As Congress considers how to reform the post-acute care system, we urge you to remain mindful that post-acute care includes Medicare Part B patients as well as those who are covered under Part A. The scrutiny that the two Congressional Committees are bringing to bear on post-acute care should not be limited to Part A. The thousands of Part B patients being treated by post-acute care providers trigger numerous regulations, rules, limitations and policy that were developed by Congress and CMS specifically for Medicare Part B and which have far more to do with payment controls than with patient care.

The following are examples of particular Part B regulatory and administrative burdens that are primarily payment-oriented and which do not produce a corresponding benefit to patients. These include:

- **Therapy Caps:** This arbitrary annual dollar limit on the amount that Medicare will pay for occupational therapy ($1,900 for 2013) and a combined annual limit to the amount that Medicare will pay for physical therapy and speech-language pathology services ($1,900 for 2013) does not reflect the medical needs of patients. In fact, the very nature of the cap means that it primarily impacts the most acute patients—those who need the most therapy and therefore whose care will most likely reach the caps
- **Exceptions Process:** There is an exceptions process that Congress has extended repeatedly over the past decade, and which is effective through December 31, 2013, that permits providers to receive payment from Medicare for services provided that exceed the therapy cap amount if the therapy is reasonable and medically necessary and is justified by supporting documentation in the patient's medical record. Claims that exceed the payment cap and do not include the KX modifier are denied.
- **Manual Medical Reviews:** All claims for therapy services that are at or above the $3,700 threshold for a beneficiary who has exceeded the therapy cap for a given year are subject to a manual medical review (MMR) process conducted by MACs and RAs. Claims submitted in states participating in the Recovery Audit Prepayment Review Demonstration (Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri) are reviewed on a prepayment basis. In the other states, RAs must conduct post payment manual medical reviews of the claims. CMS has not been able to set up a process that is timely nor consistent. The

GAO detailed many failings of the program in its recent report.[6] NASL has detailed to CMS the significant burdensome nature of this process that does not always serve the patient but in most cases, delays payment for services or forces providers to file appeals simply to have their claims paid. The continual layering on of these various payment controls just continues to increase administrative burden, drives up administrative costs and pulls staff and resources away from care. The process could be much simpler.

- **Claims-Based Outcomes Reporting:** As of January 1, 2013, CMS implemented a new requirement mandating that therapy providers use non-payable G-codes and severity modifiers on claim forms to report limited functional impairment data. Providers are required to submit data on a patient's functional impairment on the date of service for the initial therapy service, at least once every 10 treatment days, on each date of service that an evaluative procedure is billed, at the time of discharge, and on the same date of service the reporting of a particular functional limitation is ended if further therapy is necessary. As of July 1, 2013, claims submitted without the functional G-code and modifier information are rejected for payment. Importantly, therapists may choose their own test and the tests are not standardized. Subsequently, the collection of this data is fundamentally flawed and will cause poor quality of data to be gathered that will misinform upcoming payment reform and outcomes reporting policy. There are multiple significant methodological problems with translating results into a single reporting structure from the batteries of tests and methods used by physical therapists, occupational therapists and speech-language pathology therapists. In addition, the reporting relies on the subjective judgment of each therapist when an underlying standardized tool is not used during treatment. We believe that the proposed methods will not produce useful information on aggregate beneficiary function and condition, therapy services furnished or on outcomes achieved. It is important to note that one of the outcomes of the DOTPA Project, discussed above, was the proposal for providers to report functional change. This reporting was to be an alternative to the therapy caps. The idea is that progress can be measured through change in functional ability. Instead, this requirement has been layered on and way it is structured, it may not even provide useable data.

- Group and Concurrent therapy (Part A) -- In recent years, CMS' has made significant changes to reimbursement based on when group therapy or concurrent therapy is utilized. In our view, these payment reductions were not reflective of the clinical needs of the beneficiaries, and as a result therapists have lost the ability to utilize group and concurrent therapy in the most clinically effective manner. For example, CMS's policy is to define group therapy as therapy provided simultaneously to exactly four patients yet providers must allocate (or divide) the total minutes by four for purposes of reimbursement. This is true even if three patients are in the group by design or if four are in the group but one happens to be sick and misses therapy. In response to comments on

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[6] GAO: Medicare Outpatient Therapy: Implementation of the 2012 Manual Medical Review Process. July 2013.

this policy, CMS noted that it had conducted a literature search and could not find research data to support any prescribed number of participants for a group session, and yet it established the policy anyway and dismissed findings from an NASL study that found the industry average for group sessions to be three patients.

- Multiple Procedure and Payment Reduction (MPPR)—This policy allows full payment for the therapy service with the highest practice expense (PE) value, but then reduces the payment for the PE component of the second and subsequent procedures furnished on the same day for the same patient by 50%. This policy is seriously flawed when applied to therapies provided in the nursing facility setting. CMS did not analyze or consider the nursing facility setting and the clinical characteristics of the patients served there – who often require multiple therapies in a day. Nursing facility patients may receive PT in the morning and OT later in the day due to clinical considerations and operational realities. The 50% MPPR impact results in a 6-20% revenue loss for NASL members—effectively robbing the system of resources with no corresponding gain to patients in care quality. Obviously, the 2% sequester is an additional cut.

Several points arise from these examples above. CMS policy stresses efficiency of health care delivery under Medicare, yet in the group and concurrent therapy example, providers are pushed into set practice patterns that may not optimize efficiency. Providers are in a far better position to understand what the patient needs and how to establish the plan of care to meet the patient's needs. CMS continues to add complexity through layer after layer of policies in payment rule after payment rule. Clearly, this piling on is serving as a proxy to determine if quality care is being provided. Unfortunately, these artificial proxies are not showing quality but rather are increasing the provider's burden without any corresponding increase in the patient's experience or care quality. As new payment models are tested, these models should include methods to measures progress through change in functional ability. It is time to unshackle therapy providers from the burdens that have little or nothing to contribute to care quality yet which consume resources in terms of costs and therapist's time.

Patient Navigation Function

We believe a post-acute care system that is focused effectively on the needs of the patient must include a patient navigation function that is capable of assessing the full range of needs of each patient as he/she transitions to and possibly across post-acute care providers. This type of function is vital to ensure that the patient receives the right care in the right setting at the right time. The navigator would have knowledge of the full spectrum of post-acute care and would utilize a universal assessment instrument as discussed above to determine the best placement and treatment of a patient, taking into account such factors as the patient's age, medical needs, functional status, specific caregiver needs and importantly, the optimal outcome sought for the patient. The navigator also must be able to track the patient's progress through the system and work with providers to make appropriate adjustments in the patient's care pathway, including transitions from one type of provider to another. This function would have knowledge of the

available settings for care for the patient, including what may not be available to the patient in rural areas. Without such a patient navigation component, the post-acute care sector will continue to be a collection of independent providers that, depending on the circumstances, may, or may not, consult with each other effectively to coordinate their care for a patient.

In addition, part and parcel with the navigator initiative would be the collection of data as to best practices, cost-effectiveness, clinical effectiveness and related areas. Perhaps just as importantly, much of this data should be made available in standardized formats to providers to assist in their efforts to provide the best care possible to their patients.

Testing of Bundled Payments

Based on the questions included in the Committees' June 19th letter, it is apparent that there is considerable interest in applying bundling principles to post-acute care. As the Bundled Payments for Care Improvement Initiative makes clear, however, bundling can be defined in many ways. Several NASL members are participating in the BPCI Initiative. We do not have a particular approach to recommend at this time as the Initiative is still getting off the ground, but we do believe strongly that whatever approach Congress ultimately decides on (if any), that it must be pilot-tested extensively before it is applied to the post-acute care sector on a national scale. We simply do not have a model that can be implemented immediately.

As the Medicare Shared Savings Program and the Pioneer ACO program go forward, we are learning that models on paper often do not work precisely as predicted. The importance of the post-acute care area to the health of our citizens, as well as to any meaningful efforts at overall health reform, requires policymakers to be extremely cautious in making far-reaching changes to it. It should be noted that MedPAC has been studying post-acute care reform for several years, and it still is not at the point where it can offer specific recommendations to Congress for how to proceed. We know Congress takes the complexities of post-acute care seriously, and the best path forward – perhaps the only path – is to test one or more models prior to instituting any restructuring of this area.

Health Information Technology

NASL has been actively involved in health information technology issues for more than a decade as a founding member of the Long Term and Post-Acute Care Health Information Technology Collaborative. NASL members including vendors developing clinical, billing, staffing and point of care systems have worked with the Office of the National Coordinator for Health Information Technology (ONC) and Standards & Interoperability Framework since its inception to develop interoperability standards needed to advance the use of electronic health records and health information exchange across the healthcare continuum. Despite the fact that the landmark legislation, The Health Information Technology for Economic and Clinical Health (HITECH) Act left out the long term and post-acute care sector in terms of incentive programs, NASL members are moving ahead regardless in working with the ONC to develop standards and further the adoption of health IT. As the Committees deliberate on post-acute care reform, please keep in mind that all information and data that CMS and other federal partners would want to collect

in order to improve the system can only be collected and is predicated on widespread adoption and use of truly interoperable health IT. This includes information gathered from providers such as standardized patient assessments across settings (CARE tool and items), reporting of outcome measures, claims data and patient care records.

Skilled Nursing Facility Margins

The first page of the June 19th letter contains a chart that sets out annual Medicare expenditures, annual Medicare beneficiaries and average Medicare margins by post-acute care setting (home health, SNF, IRF and LTCH). SNFs are listed in the chart as having an average Medicare margin of 22-24%. We believe that range is significantly inflated and seriously misleading, in that the chart does not reflect the SNFs' total margins, i.e., the margins that also account for their Medicaid patients as well as other indigent patients.

The Kaiser Commission on Medicaid and the Uninsured, in a report issued in June, 2013 entitled "Improving the Financial Accountability of Nursing Facilities," stated that in 2010 "U.S. aggregate total nursing facility profit margins for all payers including Medicare, Medicaid, and other payers were 3.6%, and one-quarter of nursing facilities had total profit margins at or below -1.3%...." Similarly, the data analytics firm Avalere stated in a report issued in January 2012 that Medicaid payment rates are below the cost of services for Medicaid-funded residents in virtually every state. We accept that the margins for Medicare Part A post-acute patients are higher than other payment classes, but such payments and margins are off-set by the payment rates for Medicaid patients and residents, for which the average SNF does not cover its operating costs per resident at current, daily Medicaid rates. As a result, the chart presents a misleading picture of how post-acute providers are faring in the current environment and of their ability to absorb substantial payment reductions in any new post-acute care system. The bottom line for NASL members is that providers need adequate resources to meet beneficiary need.

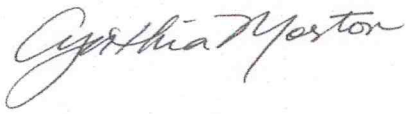
In our view, any successful reform of this area will require an understanding of how the various payment systems interact with each other. Frankly, if the Committees focus only on the Medicare program, they simply will be perpetuating the current fragmentation in policy and practice that besets this sector at the present time. We need to look at these very complex issues in a comprehensive manner, which includes the full array of stresses under which post-acute providers do business.

Conclusion

We urge the Committees to consider the concerns and recommendations contained in our letter. NASL has been at the table urging for and contributing to reform of therapy cap policies. Beneficiaries are confused and financially burdened by this labyrinth of rules and reimbursement policies. Providers are confused and burdened by the same web of policies. We must accept that limiting access to rehabilitation services is just as objectionable as denied access to prescribed medications. Both are medically necessary and both must be accessible to the beneficiary for the full duration of the treatment. It is time to stabilize the current hodgepodge of policy by making

certain short term changes while instructing CMS to begin testing payment models so a long term solution can be established. NASL is committed to working with you on thoughtful reform and applauds and thanks you for your efforts to continue to reach out to stakeholders for input and comment. If you have questions regarding our recommendations, I can be reached at (202) 803-2385, or Cynthia@NASL.org.

Sincerely,



Cynthia K. Morton
Executive Vice President

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 instituitional**
Mean age (SD)	81.1 (11.1)	78.8 (11.5)	71.1 (10.8)	70.8 (12.5)	73.6 (13.4)	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%	39%	29%	43%	36%
75-84	32%	35%	29%	29%	31%	30%	32%
≥ 85	45%	36%	9%	11%	21%	9%	14%
Sex							
Male	30%	34%	39%	37%	36%	35%	36%
Female	70%	66%	62%	63%	64%	65%	64%
Race							
White	86%	85%	88%	86%	83%	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***	***1,806***

** 5,285 beneficiaries with unknown setting*

Based on 2010 5% Medicare SAFs

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%
Diability 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***	***2,261***	***10,238***

**20,971 beneficiaries with unknown discipline*

Appendix 1
Typical Nursing Facility Patients Receiving Part B outpatient therapy

1. Patient is an 86 year old female with a diagnosis of right hip fracture, s/p THR 2.5 weeks ago. Patient is non-weight bearing. While in the hospital the patient suffered acute respiratory failure and exacerbation of Chronic Heart Failure (CHF) and was briefly placed on a ventilator. Patient's past medical history includes: CHF, AFib, MI, mitral valve regurgitation, Type 2 DM and osteoporosis. Prior to hospital admission the patient lived at home with her older sister who has Alzheimer's disease. Patient is the primary caregiver for the sister. Due to fear of consequences (possible separation and long-term care placement) to her and her sister, patient did not report to her physician that she was increasingly unsteady on her feet for 2 months prior to the fall in a grocery store that caused her admission and THR surgery. Patient's level of function prior to the recent decline was independent community ambulatory and driver. Plan of Care includes physical therapy interventions, referral to and extensive coordination with occupational therapy, social services and home care provider.

2. Patient is an 82 year old man who is a resident in the long term care facility. He has a past medical history of CHF, hypertension, and coronary artery disease. Four months ago he was living at home independent in all ADLs and ambulating around his home with a straight cane. He fell at home and was unable to get up without assistance; he was discovered 3 days later and admitted to the long term care facility in August. Nursing referred the patient to rehab in January because he required more assistance with safe ambulation and transfers. Patient presents with impaired lower extremity strength, moderate assistance with transfers, impaired sitting and standing balance, and unable to ambulate due to dizziness. He has poor safety awareness and is oriented x 1. He also complains of pain in bilateral knees = 5/10. Focus of treatment initially will be pre-gait activities in the parallel bars, lower extremity strengthening and pain management, and improvement in functional transfers. Long term goals include modified independent with functional transfers and modified independent gait with rolling walker functional distances.

3. A 75 year old male reports bilateral knee pain s/p fall last week while walking down hall of nursing facility with a rolling walker. He is still able to walk to the dining room but it is observed he is ambulating at a much slower pace and is attending fewer activities. Nursing referred to physical therapy for assessment and follow up as indicated. Patient history includes diagnosis of osteoarthritis in bilateral knees. Diagnostic exam, including radiography post fall, revealed no fractures but did confirm moderate osteoarthritis in bilateral knees with degenerative changes and narrowing of joint space. Exam revealed no ligamentous laxity and range of motion was within functional limits. Functional assessment revealed moderate limitations to patient's daily activities. Plan of care includes physical therapy to decrease pain and improve mobility. Plan of care also includes the establishment of a restorative nursing program post discharge from physical therapy.

4. A 78 year old female was referred to physical therapy due to an increase in self-reported pain in both her knees r/t to Arthritis, which has decreased her ability to transfer without the use of her cane. Despite several attempts by nursing to manage the pain through meds, the patient continues to report 6 to 8/10 pain in B Knees, and therefore a referral was made to rehab for pain management and decrease her need to use an AD (cane) for transfers. The patient has been participating in physical therapy for the past 12 visits (over 3 weeks) to remediate her painful knees and increased difficulty to perform transfers without her AD. Patient's therapy has focused on the use of modalities to B Knees for pain management and quadriceps strengthening, progressive resistive strength training, postural education and update to her HEP/RNA program. This is the first week that the patient has been able to achieve full ROM with

minimal pain (reports 2/10 pain) and is now able to perform sit to stands independently and transfer without the use of an AD (cane).

5. An 80 year-old former engineer experienced multiple traumatic injuries following a motor vehicle accident. He underwent surgery for a right hip fracture and is non-weight bearing. He used an AFO on the left due to a dorsiflexion weakness from an injury to his personal nerve. There is an open wound on his left thigh which is covered with a dressing. Other co-morbidities include CHF and diabetes. Prior to the accident he lived on the second floor of an independent senior living apartment complex and volunteered 3 times/week at the local food bank, which is where he met his current lady-friend. No other activity limitations. He is currently in a wheelchair and hopes to return to his previous living environment and previous level of activity. Treatment focus is wound management, neuromuscular reeducation, gait training, functional training and therapeutic activities.

6. An 75 year female that was living independently alone at home without any assistive devices and active in her community. She suffers a MCA CVA with Right Hemiplegia, Dysphagia, and Aphasia. She has received skilled physical therapy, occupational therapy, and speech language pathology services under her SNF 100 days and has made excellent steady progress from Total Dependence x 2 person with functional mobility/basic self-care and NPO status to minimal assist with a hemi walker for transfers and gait x 20', minimal assist with basic self-care and improved expressive communication, and ability to tolerate a PO diet consistency of nectar thick liquids and pureed diet. She continues to require skilled PT, OT, and SLP services under Part B to return back to prior functional level and return home.

Treatment focus is on Neuromuscular Reeducation utilizing NDT and motor control techniques in adjunct with neuromuscular estim, gait training with use of AFO and progression of assistive device, balance training, functional mobility training. She will also require ongoing skilled speech therapy for treatment of her aphasia and dysphagia.

7. An 85 year old male that is s/p CVA X 1 year that resides in the LTC facility. He received extensive rehab a year ago for his left hemiplegia. At the end of his course of rehab, he presented with left lower extremity hemiplegia with trace ankle muscle strength, was able to transfer with moderate assist and stand during functional activities with use of grab bar x 3 minutes with minimal assist. He was not able to gait at that time and a restorative nursing program was established. He has been receiving RNA services and was referred to physical therapy for improvement in standing and transfer ability. RNA and patient also report improved sensation in left lower extremity and some visible movement at ankle. The rehab evaluation reveals increased muscle tone and volitional movement of left lower extremity and improved standing balance.

Treatment focuses on neuromuscular reeducation, neuromuscular electrical stimulation, pre-gait training progressing to gait training, orthotic fitting and training for an AFO, functional mobility training, development / training of revised RNA plan, and staff/patient training.

8. A 75 year old female s/p CVA with right lower extremity spasticity and multi infarct dementia. She has been able to walk with nursing to the bathroom with use of a hemi walker. Upon completion of a monthly nursing summary, the nurses notice a decline in the patient's ability to assist with gait and

refers to rehab. The physical therapy evaluation reveals increased spasticity, decreased knee extension range of motion, and decline in gait to maximal assist to walk short distances.

Treatment focuses on daily treatment to focus on improved gait and transfer ability and contracture management. Treatment included: neuromuscular reeducation, neuromuscular electrical stimulation, short wave diathermy, gait retraining, functional mobility training, therapeutic exercise and caregiver education.