National Association for the Support of Long Term Care

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August 19, 2013

The Honorable Max Baucus
Chairman, Senate Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member, Senate Finance Committee
U. S. Senate
Washington, DC 20510

The Honorable Dave Camp
Chairman, House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander M. Levin
Ranking Member, House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen and Ranking Members:

NASL is a trade association representing ancillary service providers to long term and post-acute care settings. NASL-member rehabilitation companies collectively employ more than 300,000 individuals including speech-language pathologists (SLPs), physical therapists (PTs) and occupational therapists (OTs). These therapy professionals provide therapy to hundreds of thousands of patients, primarily in institutional settings such as nursing facilities, but also in other settings in the long term and post-acute care continuum. NASL also represents providers and other ancillary service providers including information technology developers, suppliers of durable medical equipment, nursing and therapy product and equipment, labs, portable x-ray and diagnostic testing services specializing in the long term and post-acute care setting.

This letter is in response to your June 19th joint request for comments on avenues for post-acute care reform that advance the goal of improving patient quality of care and improving care transitions, while rationalizing payment systems and payment reforms. We understand and appreciate Congress' interest in exploring changes to the post-acute care sector. We are extremely pleased that you have invited interested stakeholders such as NASL to work with you in this process.

Summary of NASL's Concerns and Recommendations

1. The arbitrary nature of the therapy cap policies has a detrimental impact on patients in nursing facilities because care patterns are different for these patients. In order to achieve function and quality of life, data shows that patients in nursing facilities typically require skilled therapy services due to the chronic nature and/or potential for exacerbation of their medical conditions, and thus they are subject to therapy cap policies that have a disproportionate impact on the oldest and sickest Medicare patients. Many of whom are already challenged to pay the mandatory Medicare Part B co-pay.

2. Current Part B outpatient therapy policy has become a hodgepodge of cost controls that are not focused on the needs of the patient. Until a new payment model is established, the

rehabilitation sector will continue to need an extension of the exceptions process to the therapy caps. Additionally, other short term changes are needed including improvements to the manual medical review (MMR) process to make it more workable to patients and providers alike.

3. A universal assessment tool across all post-acute care settings is absolutely essential for the identification of the entire array of a patient's health issues so that there could be subsequent identification of the right provider, the right setting and the right time for the patient's treatment.

4. Post-acute care reform must include the removal of regulatory requirements that do not advance quality of care, and this would encompass all non-essential elements of program compliance. The focus of reforms should promote efficiency in the care of Medicare beneficiaries while assuring compliance, so healthcare practitioners can properly focus their efforts on delivering their vital services.

5. Any post-acute care reform should include the Medicare Part A and B patients and the treatments they receive from post-acute care providers, and there should be one set of regulatory requirements for both Part A and Part B services provided to post-acute care patients.

6. An independent, navigational function that reflects knowledge of the full spectrum of post-acute care settings and which can fully assess the beneficiary's condition and needs, and then can guide or direct the beneficiary to the appropriate post-acute setting, is vital to the success of any integrated or coordinated post-acute care system.

7. Any approach to implement bundled payments should be extensively tested prior to its application on a nationwide scale.

8. Congress should consider the total margins of post-acute care providers—specifically SNFs--which account for Medicaid patients as well as other indigent patient populations, when considering Medicare payment and structural reforms.

Rehabilitative Therapy Is Integral to Post-Acute Care

Throughout the entire post-acute care delivery system, the provider's primary goal is to improve the well-being and physical abilities of each patient so that they may enjoy the highest quality of life possible. Regardless of the setting in which care is delivered, rehabilitative therapies have been proven to be an essential component in delivering improved patient outcomes. Nursing facilities serve a vital role in providing therapy services as they treat approximately one-half of all post-acute patients. The nursing facility setting differs from other settings in the number and diversity of therapy services that their patients receive. Patients cared for in nursing facilities often need more than one type of rehabilitation therapy and, in some cases, all three types of therapies. For example, a nursing facility patient recovering from a leg fracture would need physical therapy to rebuild the lost muscle strength, to learn to walk using an assistive device,

such as a walker or a cane, and to regain balance to minimize the risk of falling, which could lead to serious and costly complications. The patient also may receive occupational therapy to promote independent function and to enable the patient to be discharged to the community. These OT services may include teaching the patient how to safely bathe, *i.e.* for example, how to get in and out of a bath or shower with a broken leg, and how to navigate the kitchen, so that the patient could safely cook a meal and transport dishes to and from a table while using a walker and how to transfer safely in and out of a car. The patient may also require SLP services to assess cognitive function and address deficits through retraining and compensatory techniques, *i.e.* working on organizational abilities and task sequencing to enable the patient to effectively manage and administer medications and avoid re-hospitalization due to medication errors.

Nursing facilities simultaneously care for a longer-stay population, most of whom have medically complex needs and serious functional limitations. This population also relies on therapy services to improve clinical and functional outcomes, as well as to maintain their current level of independence. Nursing facilities provide services to the recently hospitalized with the statutorily mandated goal of restoring individuals to their highest practicable level of functioning Physical therapy, for example, plays an important role in reducing the risk of falls by working to improve beneficiaries' strength and balance. Falls are serious adverse events, which are responsible for the majority of hip fractures in elderly women. Rehabilitative therapy also is essential to achieving other important goals, such as reducing pain and maintaining the ability to swallow food. The Omnibus Budget Reconciliation Act of 1987 requires that, "A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care…" This means that nursing facilities must provide the necessary services, including rehabilitation therapy, that enable a patient to maintain the highest level of functioning possible for that person.

The Benefits of Therapy

Patients who receive some type of therapy or combination of therapy services almost always experience greater improvements in clinical and functional capabilities compared to patients who do not receive therapy. Benefits of rehabilitation therapy include improvements in mobility and self-care, increased probability of discharge to the community, fewer re hospitalizations, and improved speech and cognition. Studies have found that increased intensity of services can accelerate and improve outcomes. Therapy treatments and greater therapy intensity (minutes of therapy per day/week) was associated with better outcomes in terms of reduced lengths of stay and functional improvement for patients who suffer from stroke, orthopedic conditions, and cardiovascular and pulmonary conditions and are receiving rehabilitation in the SNF setting.[1] Conversely, research also indicates that absent therapy for patients experiencing movement problems can be further impaired when their access to physical therapy is denied. There is a resultant 20% loss in lower extremity muscle strength with bed rest so a patient who is non-

[1] Source: Diane Jette, RL Warren, C Wirtalla. The relationship between therapy intensity and outcomes of rehabilitation in skilled nursing facilities. (March 2005), Archives of Physical Medicine and Rehabilitation.

ambulatory, or who requires assistance to ambulate and does not receive that assistance will likely lose lower extremity muscle strength at a rate of 20% per week.[2]

Therapies Are Distinct and Separate

Over the years, there have been legislative and regulatory efforts to combine physical, occupational, and speech-language therapies into one consolidated rehabilitation category. This approach is critically flawed and not in the best interests of the patient for quality patient care and recovery. Each therapy type is distinct and each plays a unique and separate role in improving patients' function and independence. Often, two or more therapies are utilized based on the multiple needs of the patient – complementing or building on one another – in order to restore function and manage risk of adverse events, such as falls. CMS' regulations reflect this distinction. Therapists in each therapy discipline are highly-trained professionals who excel in facilitating functional improvements in aging adults. These skills are critically important across the post-acute spectrum to maximize functional abilities of Medicare beneficiaries, which greatly reduces costs of care while improving the quality of the lives of those treated.

Medicare's Part B Outpatient Therapy Benefit

We would like to begin our analysis of possible post-acute care reforms with the Medicare Part B outpatient therapy benefit. Please understand that many of these patients receive therapy services under Part B coverage as a continuation of post-acute care treatment, as for many, clinical/functional needs extend beyond the 100 days of Part A coverage. Also, many beneficiaries experience exacerbations of conditions and need additional therapies post discharge from their Part A coverage period. The Part B therapy benefit is complicated, encompasses several different settings (some of which are inpatient) with beneficiaries at varying acuity levels, and coverage is individualized to the three distinct therapy disciplines of physical therapy, occupational therapy, speech language pathology. Although the benefit is described by statute as "outpatient therapy", the therapies are delivered in inpatient settings, such as nursing homes and hospitals, as well as outpatient settings such as the private office. This, of course, only adds to the complexity. Once prescribed by a physician, Medicare Part B covers therapy services for a patient in a SNF/NF if:

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[2] Protecting muscle mass and function in older adults during bed rest Kirk L. English, Douglas Paddon-Jones Current Opinion in Clinical Nutrition & Metabolic Care. January 2010. Also, Effects of Extended Bed Rest—Immobilization and Inactivity Thomas E. Strax, M.D., Priscila Gonzalez, M.D., and Sara Cuccurullo, M.D. Physical Medicine and Rehabilitation Board Review 2004.

- A patient is a long-term resident of a care facility who has a documented need for skilled therapy;
- The patient's stay in the facility is not preceded by a qualifying 3-day hospital stay (if so, coverage is Medicare Part A); or
- If a resident has exhausted his/her 100-days of SNF Medicare Part A coverage and still demonstrates medical necessity for skilled therapy services.

Unfortunately, despite the many connecting issues for SNF patients between Part A and Part B coverage, the Part B outpatient therapy benefit often is viewed in a vacuum, largely due to the focus on the therapy cap. This has promoted the notion that patients' interaction with the therapy cap policies is a stand-alone issue. As explained above, that type of thinking is simplistic and misleading.

We strongly believe that Congress' analysis should include both the Part A and B components of rehabilitative therapy and develop one set of rules that apply to both. The separate payment rules for Part A and Part B therapy have little to do with the medical needs of the beneficiary. In fact, a SNF patient who is a Part A-eligible patient on the 100th day of his/her stay and then becomes a Part-B eligible patient on the 101st day because he/she has exhausted the 100 day SNF benefit continues to have the same medical needs. The only change is in the billing and payer status, not in the patient's medical condition or needs. Yet, when the patient becomes Part B, multiple layers of administrative burdens descend on the provider with an entirely new set of rules and an entirely new payment system—the physician fee schedule (PFS). As we explain below in our comments on burdensome regulations, Congress should focus on whether these rules primarily add value to the beneficiary or whether they primarily add costs to the provider, and apply only on those rules that protect and improve the care provided to the patient.

A New Payment Methodology Continues to be Needed

In addition, we support efforts to stabilize the current system and move towards an alternative or new payment system for Part B outpatient therapy. As the PFS determines payment for Part B outpatient therapies, it is essential that any modifications to the PFS preserve the ability of outpatient therapy providers to provide treatment for Medicare beneficiaries. Current Part B outpatient therapy policy has become a hodgepodge of cost controls that are not focused on the needs of the patient. NASL supports the development of a new payment system for Part B outpatient therapy that takes the patient into account and reflects key factors involving clinical diagnoses, complexity of rehabilitative treatments and episodes of care.

Several years ago, Congress directed CMS to develop an alternative payment system for Part B outpatient therapy. In 2007, CMS established a research project titled Developing Outpatient Therapy Payment Alternatives (DOTPA). In addition, CMS commissioned the Short Term Alternatives for Therapy Services (STATS) project, and received a final report of short term alternatives in 2010 which included recommendations for pilot testing. The purposes of these projects were to identify, collect and analyze therapy-related information related to beneficiary need and the effectiveness of outpatient therapy services. The ultimate goal was to develop

payment method alternatives to the current cap on therapy. Despite the extensive time and resources put towards these projects by CMS, including members of NASL and many others in the industry, CMS has still not brought forward potential reimbursement models.

Congress Should Instruct CMS to Test Models

With the lack of action by CMS, the therapy sector has been working to bring forward models for payment reform. NASL's work with The Moran Company in 2008 tested the feasibility of payment in nursing facility settings based on patient condition. This work demonstrated that a prospective payment system based on episodes of care for Medicare Part B therapies could be created. NASL continues to work with The Moran Company to develop alternative approaches based on an episodic payment model, which is both easier for clinicians to manage and more amendable to introduction of quality measures and value-based purchasing mechanisms. Other organizations, including the American Physical Therapy Association and the American Occupational Therapy Association are pursuing payment changes through coding reform. NASL has provided comments on these reforms. The time has come to test these models including episodic payment, coding changes and others.

Short Term Improvements Until a New Payment Model is Deployed

Obviously, the testing and evaluation of models will take time and thus, nursing facility patients will be subject to the arbitrary nature of the therapy cap policies for several more years. Until a new model can be deployed, the rehabilitation sector and its patients will continue to need an extension of the exceptions process to the therapy caps. Additionally, other short term changes are needed including improvements to the MMR process to make it more workable for patients and providers alike. We recommend the following changes to the MMR:

- Greater transparency of the process – Congress or CMS should provide a clearer articulation of the process for providers and patients, and should set timelines at each point in the process. Currently only the Recovery Auditors (RAs) are held to a suggested 10 day timeline, and even that is not routinely enforced by CMS. No timeframe has been established for the length of time for the MACs to send claims to the RAs.
- Greater accountability of the process -- There are many points along the MMR pathway that need attention to be sure claims are not held up and patients should not have to wait for review. As an example, a RA has held claims in limbo for 45-50 days without any activity until CMS was alerted. How is CMS monitoring the RAs and the MACs on issues like this and at what time intervals in order to identify and address problems? Establishing timelines and holding contractors accountable is essential. Providers expect claims to move through the system. Clinical decision-making can be delayed when claims are delayed, and when the providers are impacted, the beneficiaries are impacted. Providers need to know what to expect with MMR so that they can communicate effectively with their patients and make the appropriate clinical decisions.

- Greater predictability of the process—Since October 2012, NASL has documented significant problems with MMR and these were shared with CMS. Some providers have received scant response on 2013 claims and of those responses received, many are now in the denial appeals process. When the MMR process holds up claims, it does not just include services in excess of $3700, but for the entirety of a claim which often includes amounts up to the $3700 as well. So, a provider is not paid for the therapy services provided to a patient and if the provider must go through the appeals process, they will not be paid for months and sometimes years—for the entire claim.

- When providers continually experience claims not being paid or delayed, this may cause the provider to re-assess whether they can handle future patients because they may not have the cash flow and other resources to continue to provide care under these circumstances to Medicare beneficiaries. The provider to evaluate what options they have to handle future patient needs which can cause access problems.

Profile of the Therapy Patient in a Nursing Facility: Patients in Nursing Facilities Are Older and More Medically Complex

A Medicare beneficiary receiving Part B outpatient therapy in a nursing facility is usually more medically complex and has more co-morbidities than patients in non-institutional settings. Nursing facility patients generally are older, and have particular characteristics that come with being older—they often are more frail with greater physical dependencies. The mean age for those receiving therapy in nursing facilities is age 81, with a significant percentage, 45%, who are above age 85.[3] This is in contrast to the patients receiving therapy in private office settings, where the mean age is 71. CMS' data shows that two-thirds of Medicare beneficiaries have multiple chronic conditions and that multiple chronic conditions increase with age.[4] Multiple chronic conditions typically affect a patient's response to therapy. These patients have an increased likelihood of dementia or psychiatric illness, and lesser cognitive engagement can result in needing extended time to reach goals. Because patients in nursing facilities need 24 hour, 7-day a week care, they are less independent in general. These patients are more likely to be dually eligible and more likely to be female.

See descriptions at Appendix A of typical nursing facility patients receiving Part B outpatient therapy.

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[3]See Table 1 **"The Characteristics of Part B Therapy Patients in Nursing Facility and Office Settings are Distinctly Different"** developed by The Moran Company based on an Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates.

[4] See page 10-11. Chronic Conditions Among Medicare Beneficiaries, Chart book: 2012 Edition.

Why Therapy Cap Policies are Detrimental to Nursing Facility Patients: Care Patterns Are Different for Nursing Facility Patients

The co-morbidities, multiple diagnosis and complex medical needs of the beneficiaries in nursing facilities often result in higher levels of care as ordered by their physician. In fact, research undertaken by The Moran Company for NASL vividly shows that a larger proportion of patients receiving therapy in nursing facilities from multiple disciplines reach the therapy caps and thresholds compared to patients receiving therapy from only one discipline. This is in contrast to office-based outpatient therapy which overwhelmingly consists of beneficiaries receiving only physical therapy services. The Moran Company research made the following key conclusions:[5]

- Beneficiaries receiving therapy from multiple disciplines are significantly older than those receiving only physical therapy.
- Beneficiaries receiving therapy from multiple disciplines are significantly more likely to be poor (dually eligible) than those receiving only physical therapy.
- Beneficiaries receiving therapy from multiple disciplines are significantly more likely to be black.
- Beneficiaries receiving therapy from multiple disciplines are most likely to exceed the cap and manual medical review threshold.

Patients receiving Part B therapy in nursing facilities exceed the caps and thresholds at a higher proportion than those receiving therapy in other settings.

Did the Patient Receive Therapy in a NF?	Number of patients	% of Total Patients	Number of Patients Hitting the PT/SLP Cap	% of Total Patients who Hit the PT/SLP Cap	Number of Patients Hitting the PT/SLP Medical Review Threshold	% of Total Patients who Hit the PT/SLP Medical Review Threshold	Number of Patients Hitting the OT Cap	% of Total Patients who Hit the OT Cap	Number of Patients Hitting the OT Medical Review Threshold	% of Total Patients who Hit the OT Medical Review Threshold
YES	865,000	16%	282,760	31%	122,360	39%	153,480	71%	56,620	73%
NO	4,653,800	84%	635,100	69%	187,940	61%	62,380	29%	20,640	27%
All Therapy Patients (with known site of services)	5,518,800	100%	917,860	100%	310,300	100%	215,860	100%	77,260	100%

National Estimates based on 5% Standard Analytic Files for 2010

The table above illustrates further conclusions developed by The Moran Company on the impact of therapy cap payment policies on Medicare beneficiaries receiving therapy in nursing facilities. The chart shows the following:

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[5]See Table 2 "**Multi-disciplinary Part B Patients Have Different Demographic Characteristics"** developed by The Moran Company based on an Analysis of 2010 Standard Analytic Files by The Moran Company, national estimates.

- More than 5 million patients receive Part B outpatient therapy--16% of those patients receive their therapy in a nursing facility.
- 31% of patients exceeding the physical therapy/speech language pathology (PT/SLP) cap are in nursing facilities, or roughly double the number of patients overall that exceed the PT/SLP cap.
- 39% of patients reaching the PT/SLP manual medical review threshold are in nursing facilities.
- 71% of patients exceeding the occupational therapy (OT) cap are in nursing facilities, which is more than double the percentage of those reaching the OT cap in other settings.
- 73% of patients reaching the OT manual medical review threshold are in a nursing facility, which is more than double the percentage of those reaching the threshold in other settings.

Clearly, this data shows that nursing facility residents are disproportionately at risk to reach the therapy cap limits and the MMR. Their particular needs are often obscured as policymakers focus on the "average" patients, *i.e.*, by averaging the therapy needs of the high end users and the low end users. Current Part B therapy policies do not distinguish between beneficiaries who are treated in institutions such as nursing facilities, and thus who are often higher cost cases with co-morbidities and complex medical needs, from other beneficiaries whose needs are very different and much less acute. As a result, a beneficiary's therapy needs often are lumped together with other beneficiaries, regardless if he/she lives at home and drives to a private office setting to receive one type of therapy or if he/she resides in a nursing facility (permanently or temporarily) and who receive multiple therapy disciplines daily to recover from surgery or stroke. The one-size-fits-all policy has been a disservice to beneficiaries—especially those who need the 24 hour care of a nursing facility. NASL supports policies that are firmly focused on the needs of the patient and that take the needs of the patient into account. The imposition of MMR in October 2012 ostensibly was to provide a *medical* review that the therapy provided to the patient above $3,700 continued to be medically necessary. Now ten months into that mandate, we question whether the review is really *medically focused* as it is conducted by a fraud contractor. These reviews are not consistent across the country, and clearly the contractors cannot handle the volume of the reviews. We believe this new policy is driven primarily by cost control that is unfairly imposed on patients in nursing facilities that by virtue of CMS' own data (detailed on page 5) are the sickest and most in need of rehabilitative therapy.

As this data and multiple hearings and testimony from providers, consumers and other experts have shown over the years, arbitrary caps on therapy services discriminate against the oldest, sickest Medicare patients—those who require the most therapy for their care. No doubt that the fact that this benefit encompasses so many patients at a wide range of acuity levels has contributed to the difficulty of developing a more permanent reimbursement system. NASL supports development of a reimbursement system that is focused primarily on the patients and their needs. NASL recognizes that significant time is needed to test models that have been created and that are now in circulation, but that is unavoidable and we - Congress, CMS, providers and patients – should begin as soon as possible.

Assessment Tools and Outcome Measures

Assessment Tools

Although there are numerous assessment instruments in existence for particular types of post-acute care providers, none of these current assessment tools are adequate for broader payment reform. That is a significant failing in terms of what is needed to make sensible changes in post-acute care, since virtually everything will flow from the patient's assessment. Simply stated, there is no data collection tool that captures the total patient. Current CMS-mandated patient assessment instruments are limited and compartmentalized, each tied to particular claims processing needs specific to particular settings, providers, diagnoses or conditions. For example, the *Minimum Data Set Version 3.0 Resident Assessment and Care Screening* (MDS) is required for skilled nursing facilities, the *Outcome and Assessment Information Set (*OASIS) is required for home health agencies and the *Inpatient Rehabilitation Facility - Patient Assessment Instrument* (IRF-PAI) is required for inpatient rehabilitation facilities. A patient assessment tool that brings together all of a patient's medical and functional issues, creates a path for transitions throughout the post-acute care system, and that considers the varying acuity of patients requiring post-acute care services is essential for any meaningful reform of the post-acute care area. Without it, it is difficult to conceive how fundamental, evidence-based changes could be possible. With such an instrument, much may be done.

Unfortunately, from the rehabilitation perspective, there is no current patient assessment instrument that fully captures a post-acute care patient's functional condition and needs. For example, the MDS is often cited as an example of a modern patient assessment instrument; however, it is not a unified assessment tool. Rather, it only captures the minimum information necessary in order to categorize a SNF resident in appropriate reimbursement categories (Resource Utilization Groupings (RUGS). The MDS is quite lengthy --38 pages -- and is primarily a nursing care assessment, completed by nursing staff on day 5, day 14, day 30 day 60 and day 90 of a patient's stay. Other elements of care, such as rehabilitation and non-therapy ancillary care may be noted in the MDS but are not strictly required.

An example of the limitation of the MDS would be useful to this discussion. If a patient with pneumonia is admitted to a SNF, the SNF's nursing staff will treat the pneumonia infection with antibiotics. In contrast, the rehabilitation therapists will focus on the functional impairments that are associated with the patient's medical conditions. Speech-language pathology works on decreasing the risk of aspiration pneumonia. Occupational therapy addresses impaired activities of daily living related to the patient's debility. Physical therapy treats the patient's posture to improve respiration, and provides aerobic exercise to support lung function and progressive resistive exercises to increase muscle force output to support transfers and gait. The MDS generally will capture the primary diagnosis that the physician has used to admit the person to the SNF, but it may not reflect any of the rehabilitation services the patient requires and receives. In addition, the primary diagnosis may not remain as the primary diagnosis days or weeks into

the patient's stay in the SNF, and thus the MDS may miss the distinctions resulting from changes in the patient's condition that may result in different nursing and therapy needs.

Similarly, the IRF-PAI was developed primarily to assess quality of care for the inpatient rehabilitation facility prospective payment system. Although the assessment tool is only 3 pages, the training manual is 160 pages, which clearly indicates that this is a very complex instrument. The IRF-PAI is significantly different from other assessment tools, even those that are used in the rehabilitation area. For example, since the IRF-PAI is based on the stay in an IRF, it does not include instrumental activities of daily living, i.e., those complex and demanding activities required for independent living. These include using the telephone, traveling, walking long distances as required when living independently in a typical U.S. community setting, ability to prepare meals, taking medication, etc. Also, only admission and discharge scores are generated, which is inconsistent with other assessment tools that generate interim functional scores. Notably, the assessment instrument does not record the type of therapy or number of therapy sessions provided to a patient. Thus, while the IRF-PAI may be adequate for the IRF setting, it would fall far short of being usable in other post-acute care settings.

In addition, the new requirement for outpatient rehabilitation providers to report a patient's primary functional limitation through non-payable G-codes also does not provide a full picture of the patient's rehabilitation needs. This new reporting requirement results in incomplete information being collected since the provider may report only one deficit at a time. The provider reports the primary deficit of the patient even though post-acute patients often have multiple deficits that are treated simultaneously. Thus, for example, a provider with a stroke patient who has both swallowing and communication deficits must determine which deficit is the patient's primary deficit and report only that, which clearly does not present a full picture of the patient's rehabilitation needs. There are other significant limitations to the data that compromise its value and future use, and as a result the aggregated data will not present a full picture of the functional limitations of patients in SNFs. NASL is concerned that the use of the G-codes in this respect will not produce usable data that can be translated into productive policy.

The Continuity Assessment Record and Evaluation (CARE) tool and items may be an effective universal assessment instrument, although your questions regarding the CARE tool imply that it is in wide circulation and use, which is not the case. CMS' goal was to develop the tool and conduct a PAC payment reform demonstration in early 2008 with a report submitted to Congress in 2011. Although several NASL member experts have served on a variety of technical panels to develop the CARE tool and items, the latest version of the CARE has not been released publicly so it is difficult to comment on which aspects of it need to be improved. That said, we believe the CARE tool has the potential to be a more complete and standardized assessment than other tools, but only if it covers the full spectrum of post-acute care and care transitions among post-acute care settings and does not perpetuate the siloed limitations of the current system. Thus, to be an effective instrument in an integrated post-acute care system, it must offer a complete evaluation of the patient and his/her needs. We wish to stress the that CARE tool and items should be released and tested to determine if in fact it could become the universal assessment tool that is essential for post-acute care reform. Whether this would be integrated within

established assessments used throughout post-acute care or as an independent set of assessment items, the contents of the CARE tool and items must be released for large scale use to determine its true value and effectiveness.

Outcomes Measures for Therapy

Recognizing the need for public measures that would promote accountability of therapy services, NASL has embarked upon a project to develop outcome measures for therapy provided in nursing facilities in conjunction with the American Health Care Association (AHCA). It is clear that the absence of standardized measures for quality and value is a significant hurdle to constructing usable outcomes measurements for outpatient therapy. What exists is a patchwork quilt of different measures: some companies have their own proprietary reporting programs; discipline-specific measures that are not applicable to other services; commercially available measures that are proprietary in nature; measures that have been established by public entities such as the National Quality Forum (NQF); and measures established by CMS (Physician Quality Reporting System). We are working quickly to develop and test measures that build on CMS' CARE items and tool and pleased to have shared our work to-date with both CMS and MedPAC. We continue to brief CMS on our progress and intend to submit these measures to the NQF. As these measures are developed, we would like to work with the Committees on Phase 2, the Update Incentive Program, to develop the appropriate linkages to a payment system that recognizes appropriate, efficient and high quality care. We offer the expertise of our clinical experts to inform development of risk adjusters and other factors needed to be taken into consideration.

The ability to effectively measure outcomes also will have an important extra benefit - it would enable regulators to reduce the administrative requirements imposed on post-acute care providers because many of the current regulatory requirements are mere surrogates for what all payers would like to have – meaningful outcomes measurement. Once that can be attained, there is no need for most if not all of the outcomes-related regulatory burdens currently imposed on providers.

Burdensome Regulatory Requirements That Do Not Advance Quality Care

A number of the regulatory requirements and limitations currently imposed on post-acute care providers do not facilitate efficient and economical performance by such providers operating in integrated or otherwise coordinated systems. For example, the 3-day prior hospitalization rule, which was developed to restrain eligibility for SNF care, thereby reducing Medicare expenditures for such care, would not make sense in a system designed to ensure that the right care is provided at the right time in the right setting. A clear benefit of overhauling the siloed approach that Medicare has taken toward post-acute care would be the opportunity to re-assess this and other requirements that have little to do with the provision of quality care to Medicare beneficiaries. Most of the regulatory requirements are time-consuming and contribute to non-patient care labor costs, are duplicative or contradictory, do not contribute to the quality of care,