



TESTIMONY FOR THE WRITTEN RECORD

FROM THE

COALITION TO PRESERVE REHABILITATION

**SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES**

BENEFICIARY ACCESS TO MEDICARE OUTPATIENT REHABILITATION THERAPY

HEARING ON

“EXAMINING BIPARTISAN LEGISLATION TO IMPROVE THE MEDICARE PROGRAM”

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Chairman Burgess, Ranking Member Green, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony for the written record on behalf of the Coalition to Preserve Rehabilitation (“CPR”) on the issue of Medicare outpatient therapy caps in connection with your hearing entitled, “Examining Bipartisan Legislation to Improve the Medicare Program.” Our testimony focuses on the [discussion draft](#) legislation “To amend title XVIII of the Social Security Act to extend the therapy cap exceptions process and manual medical review under the Medicare program” currently contemplated by the House. CPR is a consumer-led, national coalition of forty-nine (49) patient, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the Center for Medicare Advocacy, the National Multiple Sclerosis Society, the Brain Injury Association of America, United Spinal Association, the Christopher and Dana Reeve Foundation, and the Falling Forward Foundation.

The Importance and Value of Rehabilitation

Intensive and ongoing rehabilitation care is vital for individuals with stroke, brain injury, multiple sclerosis, spinal cord injury, amputation and other serious disabilities and chronic conditions to improve their health status, and in the spirit of the recent *Jimmo v. Sebelius* decision, maintain their functional abilities, and prevent deterioration of function. To demonstrate the importance of rehabilitation, on June 27, 2017, CPR Coalition, along with the Habilitation Benefits (HAB) Coalition and the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition jointly hosted a bipartisan [Congressional Briefing](#) entitled *The Value Of Rehabilitation And Habilitation Services And Devices In America’s Healthcare System*. The briefing was endorsed and sponsored by 60 national organizations, attracted over 200 attendees, and included speakers [Senator Tammy Duckworth](#) (D-IL), [Representative Glenn Thompson](#) (R-PA), [Eric LeGrand](#) (a former Rutgers football star with a spinal cord injury) [Roseann Sdoia](#) (a Boston Marathon bombing survivor) [Lisa Smith](#) (a mother of a child with developmental disability who uses habilitation therapy), and [Gregory J. O’Shanick, MD](#) (President and Medical Director of the Center for Neurorehabilitation Services). The briefing attracted a large number of House and Senate staff interested in the effectiveness of rehabilitation services and devices.



Over 1 million Americans per year experience catastrophic medical events, including over 700,000 strokes, over 400,000 traumatic brain injuries, and over 12,000 spinal cord injuries, all of which necessitate intensive outpatient therapy. Outpatient rehabilitation therapy is a critical component of an overall rehabilitation plan of care for many Medicare beneficiaries, and helps such individuals recover from illness or injury, achieve health and functional status, and live as independently as possible in their homes and communities, rather than in institutionalized settings. For people with disabilities and chronic conditions, outpatient therapy services are vital to avoiding unnecessary and expensive acute care visits and preventing secondary conditions. It has been estimated that almost 70% of Medicare beneficiaries have more than one chronic condition that may require outpatient therapy.

Rehabilitation therapy has demonstrated value in increasing quality and decreasing costs to taxpayers. One [study](#) showed that occupational therapy “lead[s] to significant, lasting positive change in bodily pain, social functioning, mental health, composite mental functioning, life satisfaction, and depressive symptomatology (Clark, et. al., 1997, 2012). This intervention approach has also been shown to lead to health care savings that exceed the intervention’s modest costs (Hay, et. al., 2002).”¹ Another [study](#) showed that ““occupational therapy is the only spending category where additional spending has a statistically significant association with lower readmission rates’ for the three health conditions studied: heart failure, pneumonia, and acute myocardial infarction.”² A third [study](#) showed that rehabilitation therapy reduced nursing home admissions.³

Several case study videos produced by the Falling Forward Foundation, a CPR Coalition Steering Committee member and signatory below, further demonstrate the value of rehabilitative therapy. ["Cayden"](#) experienced spinal cord injury as a result of a car accident. He was initially paralyzed from the chest down. Thanks to rehabilitative therapy, he is currently walking with no assistance, as well as engaging in [rock climbing](#), golfing and paddle-boarding. ["Jason"](#) experienced a

¹ Hart EC and Parsons H, “Occupational Therapy: Cost-Effective Solutions for a Changing Health System,” *American Occupational Therapy Association*, 2015. Available at: <https://www.aota.org/~media/Corporate/Files/Advocacy/Federal/Fact-Sheets/Cost-Effective-Solutions-for-a-Changing-Health-System.pdf>

² “Health Policy Researchers Find Occupational Therapy is Only Spending Category That Reduces Hospital Readmissions,” *American Occupational Therapy Association*, September 2016. Available at: <https://www.aota.org/Publications-News/AOTANews/2016/Occupational-Therapy-Reduces-Hospital-Readmissions.aspx>

³ “Occupational Therapy Can Reduce Nursing Home Admissions,” *American Occupational Therapy Association*, September 2016. Available at: <https://www.aota.org/Publications-News/AOTANews/2016/Reduce-Nursing-Home-Admissions.aspx>



traumatic brain injury from a bicycle accident, which initially resulted in a loss of memory and motor function. Thanks to rehabilitative therapy, today he is able to work, drive and parent. [“Ed”](#) experienced two strokes, initially leaving him paralyzed on his left side. Because of rehabilitative therapy, today he is able to walk, dance and return to work. [“Lisa”](#) experienced a spinal cord injury from a horseback riding accident, initially leaving her paralyzed from the shoulders down. Rehabilitative therapy has enabled her to walk with a quad-cane and live independently.

History of the Medicare Outpatient Therapy Caps and Exceptions Process

2017 marks the dubious anniversary of Medicare outpatient therapy cap implementation. In 1997, as a result of the Balanced Budget Act, Congress capped the benefit for Medicare outpatient rehabilitation services (excluding hospital outpatient services until recently, when the caps were applied to these settings as well). The purpose of this policy was to address alleged overutilization of the benefit, limit Medicare spending in order to balance the federal budget, and improve the solvency of the Medicare Trust Fund. Congress established one cap of \$1,500 for physical therapy and speech language pathology services combined, and another \$1,500 cap for occupational therapy services.

Congress later delayed implementation of these caps on multiple occasions by placing a moratorium on their enforcement until 2006. The Deficit Reduction Act of 2005 (DRA) implemented the caps but coupled them with a new “exceptions process” to ensure beneficiary access to vital rehabilitation services for those whose treatment needs exceeded the therapy caps. The therapy caps and exceptions process has been extended numerous times to the present day. In 2017, annual inflation adjustments have brought the therapy cap limits to \$1,980 for each cap. Outpatient therapy “thresholds” of \$3,700 per episode were also established to further limit alleged overutilization. Once a beneficiary exceeds this threshold, Medicare contractors are permitted to perform targeted claims reviews (i.e., audits) of providers who submit these claims.

The Medicare outpatient therapy caps are particularly onerous given the recent *Jimmo v. Sebelius* decision, i.e., that Medicare coverage is available for skilled services to maintain an individual’s function, not only to improve it. Pursuant to *Jimmo*, medically necessary skilled nursing and therapy services (including outpatient therapy) provided by or under the supervision of skilled personnel are covered services by Medicare if the services are needed to improve a beneficiary’s condition, maintain the individual’s condition, or prevent or slow their decline. CPR believes that access to outpatient therapy is essential, and that patients need not demonstrate improvement in order



for skilled services to be covered as reasonable and necessary. The therapy caps and exceptions process significantly complicate compliance with *Jimmo* for Medicare beneficiaries in need of greater-than-average outpatient skilled therapy. Resolution of the therapy cap issue will eliminate obstacles to full and effective implementation of the *Jimmo* decision.

For years, annual extensions of the therapy caps and exceptions process rode along with the annual legislation to fix the Medicare Sustainable Growth Rate (SGR) formula for physician payment, which was a compelling political issue that Congress invariably passed. Now that the physician fee schedule “fix” has been permanently resolved in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a permanent repeal of the therapy caps is necessary. Whether the caps are repealed permanently or only another short-term fix is possible, the therapy cap fix needs another legislative vehicle. MACRA merely extended the therapy caps exceptions process through December 31, 2017, a necessary but not sufficient step.

If Congress passes no further legislation, the full caps (without the exceptions process) will be imposed beginning in January 2018. Therefore, the CPR Coalition strongly urges Congress to finally resolve the therapy cap issue once and for all before the end of this calendar year.

Permanent Solution is Needed, but the Exceptions Process is an Important Fall-Back Strategy

The current exceptions process provides a relatively effective solution for beneficiaries in need of therapy services that exceed the caps. An extensive list of condition codes determines which patients can receive therapy beyond the cap, as long as the services can be documented as medically necessary. This is a diagnosis-based system that accommodates most beneficiaries in need, but by definition, leaves some beneficiaries to fend for themselves once the cap applies. Still, the exceptions process is certainly better public policy than an arbitrary cap that cuts off access to therapy services when beneficiaries need them most.

The therapy cap exceptions process, however, is not fiscally sustainable over the long term. There needs to be a more comprehensive solution that resolves this perennial problem once and for all. Beneficiaries and providers alike should not be exposed to the uncertainty that accompanies the near-annual process to suspend imposition of the therapy caps as enacted twenty years ago. ***The CPR therefore advocates for an outright repeal of the therapy caps, and enactment of a thoughtful replacement policy that ensures patient access.*** That said, if Congress is not able to pass a permanent repeal bill by the end of this calendar year, it must extend the current exceptions process so that



Medicare beneficiaries who have outpatient therapy needs that exceed the caps continue to have access to rehabilitation therapy services.

The CPR Coalition understands that the cost of an outright repeal of the Medicare outpatient therapy caps may need to be mitigated through certain CMS procedures to monitor and grant judicious coverage of outpatient therapy. Some of these mitigation strategies have been debated in the context of Senator Ben Cardin (D-MD)'s efforts to help resolve this issue. We address some of these issues below.

Concerns with Prior Authorization and So-Called “Aberrant” Billers

CPR has had reservations with last year's Senate language to employ the use of prior authorization of claims submitted by “aberrant” billers, i.e., therapy providers that provide a disproportionate amount of services, in its efforts to repeal the therapy caps. Our concerns with this proposal focus on the fact that prior authorization has the potential to dilute the authority of rehabilitation professionals to practice rehabilitation medicine and could lead to significant delays in access to patient care.

Additionally, we are concerned that a focus on “aberrant” billers may misidentify for prior authorization specialty therapy practices that focus on high users of therapy services (i.e., patients with spinal cord injuries, brain injuries, stroke, etc.). That American Occupational Therapy Association (AOTA), American Speech-Language-Hearing Association (ASHA), and American Physical Therapy Association (APTA) (all CPR members and signatories below), in coordination with the Therapy Cap Coalition, have been working to try to address these concerns in revised legislative language. As the committee develops a repeal bill, any provisions targeted at controlling utilization or aberrant billers must include patient protections, so as not to delay patient care, and should not unduly target specialty providers.

Combined PT/SLP Therapy Cap is Arbitrary; Not Based on Medical Necessity

As already stated, Medicare outpatient therapy caps are arbitrary, and are not based on medical necessity. Such caps deny rehabilitative care to beneficiaries who need it most. Additionally, the combined cap of physical therapy and speech-language pathology is problematic as these are distinct clinical services that occur at different times in the continuum of care and address related but separate areas of impairment. For instance, a patient with a stroke might receive extensive physical therapy to



regain mobility but then see the cap limit their ability to obtain services to improve swallowing or the ability to communicate. This example of giving the patient a choice between walking and talking is an oft-cited example of the complicating factors and poor public policy surrounding the therapy caps.

Permanently Removing Therapy Caps Yields Long-Term Cost Savings

Permanently removing the therapy caps is in fact a sound economic decision that will save money for federal taxpayers. Short-sighted denials of additional rehabilitation lead to beneficiaries making partial recoveries, or not maintaining function that would have otherwise not been the case with adequate rehabilitation. This in turn drives up healthcare costs, as these patients require more expensive long-term care in settings such as skilled nursing facilities and nursing homes.

The taxpayer is better served in the long term if Congress invests in lifting the therapy caps and granting access to those in need depending on the severity of their illness or injury. Long-term cost savings will be derived from:

- A reduced need for long-term medical care (e.g., re-admission, nursing care to support daily living, etc.);
- Avoidance of long-term disability; and
- Increased tax revenue from people who are able to return to work.

Further evidence for the economic case for full repeal was provided by a report commissioned by the American Occupational Therapy Association (a CPR member, and signatory below) from the Moran Company. This report looked at patterns in therapy utilization, and compared therapy utilization in 2011 to 2015. The data debunked the common criticism that therapy is over-utilized. The average per beneficiary, Part B therapy spending *decreased by 8%* across all therapy types between 2011 and 2015. This compares to an *increase of 8%* in per overall beneficiary Part B spending.

CPR has long argued that the Medicare outpatient therapy caps are arbitrary and harm beneficiaries most in need of rehabilitation. CPR members believe that outpatient therapy services should be administered in the best interest of individuals needing rehabilitation, rather than on arbitrary limitations on coverage. We therefore wholeheartedly support a permanent repeal of the Medicare outpatient therapy caps, and urge this subcommittee to go beyond simply extending the current therapy



cap exceptions process. However, if a permanent repeal is not possible this year, Congress must pass an extension of the exceptions process to the therapy caps to be in effect next year. We thank the subcommittee for its leadership in addressing this critically important policy for Medicare beneficiaries and appreciate the opportunity to submit this written testimony.

Sincerely,

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Supporting Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Heart Association/American Stroke Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
Brain Injury Association of America
Christopher and Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Easterseals
Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
Lupus Foundation of America
The Michael J. Fox Foundation for Parkinson's Research
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators



The National Athletic Trainers' Association
National Council for Behavioral Health
National Council on Independent Living
National Disability Rights Network
National Multiple Sclerosis Society
National Rehabilitation Association
National Stroke Association
Paralyzed Veterans of America
Rehabilitation Engineering and Assistive Technology Society of North America
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association