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Committee on Energy and Commerce  
Subcommittee on Health

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

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On behalf of  
The American Occupational Therapy Association (AOTA)  
The American Physical Therapy Association (APTA)  
The American Speech-Language-Hearing Association (ASHA)

**Chairman Burgess, Ranking Member Green, and Members of the Health Subcommittee of the House Committee on Energy and Commerce:**

My name is Justin Moore, and I am the CEO of the American Physical Therapy Association.

On behalf of the American Occupational Therapy Association (AOTA), the American Speech-Language-Hearing Association (ASHA), and the American Physical Therapy Association (APTA), I thank you for the opportunity to provide testimony on bipartisan legislation to strengthen and improve the Medicare program. Today I will share with you our perspective on a particular policy—the exceptions process to the limitations on therapy services under Medicare Part B, which is set to expire on December 31, 2017.

The therapy caps, and the current exceptions process to them, impact a wide spectrum of patients needing rehabilitation services. In particular, the therapy caps have a disproportionate impact on older, more chronically ill beneficiaries from underserved areas, such as rural and urban population centers. Advocacy work to protect access to therapy services for these patients and consumers has resulted in almost 30 patient and professional organizations coming together with the common objective to repeal the therapy caps once and for all. I want to thank Representatives Erik Paulsen, Ron Kind, Marsha Blackburn, and Doris Matsui for championing repeal of the therapy caps by introducing H.R. 807, which currently has 177 cosponsors in the House. Companion legislation has been introduced in the Senate by Senators Ben Cardin, Dean Heller, Susan Collins, and Bob Casey. This legislation has the bipartisan support of 26 senators as of today.

Since 1997, we have worked to ensure that this arbitrary limitation on outpatient rehabilitation

services does not impede access to necessary and covered care for Medicare beneficiaries. Congress has acted 16 times to prevent this policy from negatively impacting seniors and individuals with disabilities. Today, we ask that Congress fully address this longstanding concern by repealing the therapy caps and replacing them with a thoughtful medical review policy that will protect the integrity of Medicare while ensuring timely access to care. While we appreciate the committee's focus on the issue of the therapy caps, we urge the committee to avoid extending the exceptions process again, and instead pursue a permanent fix to the therapy cap.

While the current exceptions process has provided temporary mitigation for beneficiaries against the negative impact of the therapy caps, it is not a long-term solution.

We believe it is time for Congress to fully repeal the therapy caps and replace the temporary exceptions process with a permanent fix that is more targeted, ensures that care is delivered to vulnerable patients, streamlines the ability of providers to deliver needed care, and ensures the long-term viability of the Medicare program.

### **Background of the Outpatient Therapy Caps**

As part of the Balanced Budget Act (BBA) of 1997, Congress authorized \$1,500 therapy caps on the majority of outpatient therapy services furnished under Medicare Part B: in private practice settings, physician offices, skilled nursing facilities (Part B), comprehensive outpatient rehabilitation facilities, home health agencies (Part B), and rehabilitation agencies. At the time, Congress exempted outpatient hospital settings from the therapy cap.

Due to a quirk in statutory language, it was determined that 2 caps would exist: 1 on physical therapy and speech-language pathology combined and 1 on occupational therapy services. The therapy caps authorized in the BBA were designed to be a temporary measure until the Centers for Medicare and Medicaid Services (CMS) provided an alternative payment methodology for therapy services for Congress' consideration. The authorizing language from BBA also provided for inflationary growth beginning in 2002 for the financial limit. Today the therapy cap is \$1,980 per beneficiary per year for physical therapy and speech-language language pathology services, and \$1,980 per beneficiary per year for occupational therapy, with a clinically based exceptions process.

The therapy caps originally went into effect on January 1, 1999, but were not enforced due to limitations in implementing them at the agency and local contractor level. On November 19, 1999, Congress passed the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, which placed a 2-year moratorium on the \$1,500 cap for 2000 and 2001. Congress passed legislation again in 2000 as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to extend the moratorium on the therapy caps through 2002. In 2003, CMS delayed enforcement of the therapy cap from January 1, 2003, through September 1, 2003. The therapy cap was in place from September 1, 2003, until Congress passed the Medicare Modernization Act on December 8, 2003, that extended the moratorium on the therapy cap through December 31, 2005. In other words: In the first 6 years of the therapy cap, Congress passed moratoriums on this policy 3 times, and the caps were in effect for just under 100 days.

The therapy caps again went into effect temporarily on January 1, 2006, but were quickly addressed in the Deficit Reduction Act passed by Congress on February 1, 2006, by creation of the initial exceptions process. Originally, CMS implemented a 2-tier approach of an automatic exceptions process for certain diagnoses likely to exceed the therapy cap and a manual process for clinicians to provide justification of medically necessary care above the arbitrary financial limitation of the therapy cap. Due to the difficulty in reviewing all claims submitted under the manual process, the exceptions process was modified to allow for the use of a code-based modifier to signify that therapy services above the financial limit are medically necessary and appropriate.

The Middle Class Tax Relief and Job Creations Act of 2012 implemented a manual medical review (MMR) process that began in October 2012. This process initially required a MMR of all claims over the \$3,700 threshold, prior to the services being provided. Later these reviews were handled as prepayment reviews by Medicare Administrative Contractors (MACs), and then CMS used Recovery Audit Contractors (RACs) to do prepayment reviews of claims in 12 states and postpayment reviews of claims in the other 38.

In addition to RACs being inappropriate contractors to review services that have never been paid for, the entire process of review was poorly administered and never implemented in a way that did not create a burden for providers. This was particularly true of the preapproval process (similar to the issues experienced with preapproval in 2006). The MMR process was put on hold in 2014 and 2015 due to contract issues.

In 2015 the Medicare Access and CHIP Reauthorization Act put into place a *targeted* MMR process, based on set criteria. From the perspective of the 3 therapy groups, this process has worked without undue burden or delaying care for beneficiaries. The current extension of the therapy cap exceptions process expires on December 31, 2017.

### **The Impact**

It has been estimated that almost 70% of Medicare beneficiaries have more than 1 chronic condition that may require outpatient therapy. For a patient with multiple chronic conditions, therapy services are critical to preserving or regaining function following an impairment or a major medical condition such as stroke. Medicare beneficiaries requiring extensive or multiple therapies most likely will quickly exceed the therapy cap benefit. Although the exceptions process is in place to provide a pathway to care for these individuals, the current process is only guaranteed through the end of this year.

The combined cap of physical therapy and speech-language pathology is also problematic, as these are distinct clinical services that occur at different times in the continuum of care. They address related but separate areas of impairment. A patient with a stroke might receive extensive physical therapy to regain mobility, but then the cap will limit their ability to obtain services to improve swallowing or speaking. This example of giving the patient a choice between walking and talking is an oft-cited example of the complicating factors and poor policy of the therapy cap.

Additionally, services under Medicare are required to be medically necessary, and providers must meet the required regulations to demonstrate this requirement. The therapy cap places an arbitrary stopping point to therapy regardless of the medical necessity of the services. A patient has a demonstrated need for care, and yet a policy overrides their ability to receive that care. This runs contrary to the overall policies of Medicare related to ensuring quality patient outcomes.

Congress has long known that allowing the therapy caps to go into effect would have a profound impact on patient care; that is clear from the repeated delays and extensions of the exceptions process. But the pattern of yearly extensions without a permanent solution is not in the best interest of patients, providers, or the Medicare program, as it creates uncertainty for beneficiaries and providers. We recognize and appreciate the cost of a permanent fix and appreciate Congress' work to ensure that hard caps on therapy services do not go into effect. However, the cost of a permanent fix will only continue to rise as more beneficiaries come into the Medicare system. Additionally, it appears that new models of care are discharging patients from inpatient settings earlier, and relying more and more on outpatient settings for the provision of therapy services. While these models may save the entire Medicare system money, they are shifting services from Part A to Part B. Should this pattern continue, the cost of repealing the therapy caps down the road will only increase, and so too will the negative impact on patients and outcomes. The 20 years of exceptions process extensions now has cost more than that of a permanent fix, so we urge Congress to move forward toward a solution this year, which would avoid a future of additional costly extensions.

ASHA, APTA, and AOTA believe simply extending the exceptions process yet again is not in the best interest for sustaining the long-term fiscal health of Medicare, nor does it meet the growing needs for cost-effective rehabilitation services under Medicare. The time has come to enact a replacement policy that is a permanent fix. Such a policy should build upon the lessons learned and data gathered through the current exceptions process, and current and previous medical review programs.

### **Current Exceptions Process and Medical Review**

With the passage of MACRA, the exceptions process to the therapy caps is currently in effect. Under this system, providers may request an exception on a beneficiary's behalf when their treatment exceeds the cap—\$1,980 in 2017—and the services are determined to be medically necessary. To indicate this medical necessity, the therapy provider or practitioner is required to add a KX modifier to the claim for each applicable service. By using the KX modifier, the provider attests both that (a) the services are reasonable and necessary, and (b) there is documentation of medical necessity in the beneficiary's medical record.

A second layer to the current therapy caps exceptions process is a targeted review of claims once a beneficiary's incurred expenses reaches a threshold of \$3,700. Each beneficiary's incurred expenses apply toward the threshold in the same manner as it applies to the therapy caps. There's 1 threshold for combined PT and SLP services and another threshold for OT services.

This current medical review process allows CMS to do a targeted review of claims that exceed the \$3,700 threshold rather than a review *every* claim above the threshold, as was required when



the exceptions process was first implemented in 2006 and when medical review was first implemented in 2012. Targeted medical review focuses more on providers with aberrant billing patterns when compared with their peers, or that have a high amount of hours or minutes of therapy delivered to patients in a single day. This review occurs after therapy services have been provided.

### **Lessons Learned That Inform a Replacement Proposal**

AOTA commissioned a report from the Moran Company to look at patterns in therapy utilization that might inform policy for a permanent fix. This report compared therapy utilization in 2011 (the year before medical review was implemented at the \$3,700 threshold) with 2015 (when the refined review process was first implemented). The data demonstrate 2 key findings:

**First, the average per-beneficiary, Part B therapy spending *decreased* by 8% across all therapy types between 2011 and 2015.** This compares with an *increase* of 8% in overall beneficiary Part B spending. This demonstrates that the current process of reviewing targeted claims over the \$3,700 threshold is working. Between 2011 and 2015 the proportion of overall spending above the \$3,700 threshold fell from 31% to 20% of total Medicare therapy spending for physical therapy and speech language pathology, and from 35% to 27% of occupational therapy spending. This decrease in total Medicare therapy spending on services above the threshold is the result of both a decrease in the number of beneficiaries receiving services over the threshold and a decrease in the average cost per beneficiary over the threshold. (Moran analysis Tables 3 and 4 attached).

Second, this data demonstrates that while there has been a decrease in spending above the threshold, services are still being provided and approved by the current review process. The current \$3,700 threshold and medical review process appear to be having the intended effect of controlling potentially unnecessary utilization, as seen by a decrease in per-beneficiary spending and number of beneficiaries in this category, but still maintaining a pathway for patients to receive all medically necessary services.

Representatives from the 3 therapy professional organizations have been in discussion with both Energy and Commerce Committee and Ways and Means Committee staff, as well as with Senate Finance Committee staff, about ideas for a permanent therapy cap policy. We believe that the \$3,700 threshold and current medical review process is providing appropriate oversight of therapy spending, and could be incorporated and improved in a permanent fix to ensure continuity of care, increased efficiencies, and decreased administrative burden.

One possible policy for a permanent fix could include a 3-step process of oversight of therapy claims. The first step would be to utilize the current \$3,700 threshold as a trigger for *postpayment* medical review of claims submitted by providers who meet certain criteria.

Additional oversight mechanisms could be utilized for providers on postpayment medical review who are identified as meeting additional factors; in other words, providers who are not “succeeding” under postpayment review. This oversight coupled with a pathway for therapy providers to be part of alternative payment models and other performance-based models will better align therapy services with the transition of Medicare to a value-based system.

To that end, and based on our experience with previous policies, we respectfully propose the following principles:

***1) Ensuring patient access***

Any permanent therapy cap policy should—at its core—ensure patient access to outpatient therapy services. The fundamental flaw with the policy of the therapy cap is that it is a broad barrier to care that does not take into account the individual needs of the patient. Additionally, any new policy should ensure that care is not disrupted for long periods of time. In the past, when CMS has been asked to do a broad review of a large number of claims, they have been unable to efficiently implement the policy, resulting in delayed care for patients and high administrative burden for providers. Not only is delayed care bad for the patient, but it could lead to higher costs to the program, as the beneficiary's progress may regress if care is disrupted.

***2) Targeted approach to oversight of outpatient therapy spending***

We support a mechanism to ensure appropriate delivery and utilization of outpatient therapy services. This could include targeted reviews of therapy providers whose claims exceed certain thresholds and have been identified based on specific factors. Additional scrutiny could be given to providers who continue to have claims rejected under the review process. However, any additional scrutiny, whether through postpayment review or preauthorization, should include protections for patients and ensure that care is not delayed (see principle #1). This process would be similar to the current \$3,700 threshold and postpayment medical review process. Blanket mechanisms, such as the current therapy caps or broad application of prior authorization across the patient spectrum, are not effective. They restrict patient access, do not take into account

medical severity, interrupt the continuity of care, and cannot realistically be implemented by CMS.

### ***3) Alignment with value-based and performance-based models***

We believe that therapy services provided in a qualifying Alternative Payment Model (APM) should be exempt from any permanent outpatient therapy policy. Providers who participate in APMs would already be subject to quality and outcome requirements, as well as a shared risk for the cost of care, that would ensure efficient provision of services. In addition, while therapy providers are not currently part of the MIPS program, we anticipate that these providers will be added to the program in 2019. The MIPS program provides performance-based penalties and payment adjustments to providers. Under MIPS, the therapy caps and ongoing short-term fixes could impede the ability of providers to maximize outcomes, decrease costs, and improve performance. A permanent fix is essential in order for therapy providers to effectively participate in MIPS.

### **Conclusion**

In closing, ASHA, AOTA, and APTA, along with other members of the community opposing the therapy cap, stand ready to work with the Committee to finally, after 20 years of extensions and moratoria, to repeal the therapy cap, find a permanent fix that ensures patients' access, improves the care delivered to those patients, streamlines the ability of providers to deliver that care, and ensures the long-term viability of the Medicare program. Thank you.