NARA
The Business Of Rehab

Comments of
The National Association of Rehabilitation Providers & Agencies
on CMS' Proposed
Multiple Procedure Payment Reduction Policy
August 23, 2010

The National Association of Rehabilitation Providers & Agencies (NARA) represents Medicare-certified rehabilitation agencies and other providers of physical and occupational therapy services as well as speech-language pathology services. Collectively, NARA speaks on behalf of tens of thousands of rehabilitation professionals who provide vital medical services to hundreds of thousands of Medicare beneficiaries annually. NARA has been advocating on behalf of medical rehabilitation professionals and their patients for over 30 years.

NARA has very carefully reviewed the Center for Medicare and Medicaid Services' (CMS) Proposed Notice regarding "Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2011" which was published in the Federal Register on July 13, 2010. It is beyond cavil that any significant changes in the current Medicare payment policy for outpatient therapy services will have a profound impact on the providers of such services as well as the access which Medicare patients will have to necessary care and the quality of the care which they receive. The physician fee schedule governs payment to physical, occupational, and speech-language therapy services furnished by rehabilitation agencies, as well as outpatient rehabilitation services provided by hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and home health agencies.

CMS has proffered a proposed rule which would make an unjustified and extremely harmful change to the payment policy for rehabilitation services under the physician fee schedule by extending the current Multiple Procedure Payment Reduction Policy currently used for select Medicare services such as surgical procedures and some medical imaging to certain outpatient therapy services. In short, the proposal would utilize a 50 percent payment reduction to the practice expense component of the second and subsequent therapy services for multiple therapy services provided to a single patient in a single day. According to the proposal, this policy would attach regardless of whether the services are furnished by one therapy discipline or multiple disciplines—viz. physical therapy, speech language pathology, or occupational therapy.

For the reasons delineated below, NARA vigorously opposes the extension of the MPPR Policy to therapy services. NARA's detailed examination of the proposal led it to conclude that implementation of the MPPR policy for rehabilitation services will drive many skilled rehabilitation providers from the marketplace, greatly exacerbate an existing serious shortage of rehabilitation providers, strongly discourage the entry of

new rehabilitation professionals, and deprive many Medicare beneficiaries of critical rehabilitation care. Accordingly, NARA urges CMS in the most compelling terms to abandon this proposal and actively pursue other alternatives which will not do violence to the important fabric of quality rehabilitation care which exists today.

The Proposed Extension of the MPPR Policy Undercuts Ongoing Efforts to Develop Viable Alternatives To the Outpatient therapy Caps

NARA is sensitive to CMS' desire to ensure that effective and efficient care models are utilized by rehabilitation providers. NARA (and virtually all of the rehabilitation organizations) has been, and continues to be, supportive of CMS' STAT project and other efforts to develop alternatives to current delivery and reimbursement models for therapy services. However, the proposed expansion of the MPPR policy "jumps the gun" on these ongoing efforts and is a rather clear cut repudiation of the spirit, intent, philosophy and progress made via these undertakings. Further, during the process of this recent proposed ruling, it appears that assumptions were considered and factored that NARA does not consider being an accurate reflection of the delivery of outpatient rehabilitation therapy services.

The Proposal is Predicated on Faulty Assumptions

The MPPR proposal is deficient for a number of reasons.

Utilization Patterns - The proposed ruling assumes that all outpatient therapy visits average approximately 4.0 billable procedures for each patient visit. NARA's provider network and data suggest that in most delivery models, outpatient therapy visits average between 2.8 and 3.5 billable procedures per visit. Furthermore, NARA understands that one-time patient visits were not considered by CMS and this omission further adversely skews the data which served as the predicates for CMS' conclusions about utilization and practice trends.

Cost of Doing Business Increases – It is absolutely critical that any reimbursement system take into careful account the economics and logistics of maintaining a business model that supports quality and efficient care. NARA believes that CMS lost sight of this critical fact and gave no consideration to the significant costs of doing business for rehabilitation providers and the amount they would receive in reimbursement under the new proposal. Currently rehabilitation agencies have very small margins between the cost of delivering quality physical therapy and occupational therapy and speech-language therapy services and the payments for such services which they receive from Medicare. The MPPR proposal would cause even those small margins to vanish spelling doom for many providers and causing even those that are able to survive may be forced to stop furnishing care to Medicare beneficiaries.

Continuum of Care – Approximately 20% of Medicare beneficiaries are hospitalized at least once annually. Of these beneficiaries, 35% are discharged to providers of post acute care

services, oftentimes requiring rehabilitation therapy services. The following is a breakdown of discharge destination of these beneficiaries:

- *41.1% - Skilled Nursing Facility*
- *37.4% - Home Health*
- *10.3% - Inpatient Rehab Facility*
- *9.1% - Outpatient/ambulatory therapy*
- *2.0% - Long Term Care Hospital*

Within these various provider types in the continuum of care, the following data reflects the number of beneficiaries who require utilization of more than one provider type in the continuum of care during their episode:

- *Skilled Nursing Facilities: 59%*
- *Home Health Agencies: 38.2%*
- *Inpatient Rehab Facilities: 87.7%*
- *Outpatient Therapy: 34.4%*
- *Long Term Care Hospital: 74.9%*

Source: Gage et al. (2009). Examining post-acute care relationships in an integrated hospital system, ASPE.

The above data indicates the significance of beneficiary disease / condition management trends that require the coordinated efforts of several components within the continuum of care. These components need to be carefully coordinated and aligned for quality and efficient care delivery. However, NARA understands that outpatient care provided to beneficiaries in skilled nursing facilities, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, and hospitals were not considered in CMS's assumptions and analyses underlying the proposed MPPR policy extension. Instead, the data used was pulled from private practitioner's outpatient settings as well as services provided in physician offices. This is not a fair or accurate representation of the beneficiary utilization patterns and/or delivery models provided elsewhere. Additionally, given the above data, NARA believes focus and initiatives within reform legislation that recognize "bundled payment" of post acute care providers and integration of efficiencies and outcomes measurements for beneficiaries would be compromised and/or negated with the implementation of the proposed policy of MPPR.

The MPPR Policy Contradicts the Focus of Health Care Reform Objectives

NARA believes that threaded throughout reform legislation is the intent for health care providers to become more accountable and responsible for cost and efficiency of care delivery models (i.e. Accountable Care Organizations). Organizations and providers of outpatient rehabilitation therapy services have for years been working within the context of regulatory controls such as the Therapy Caps and the 8-Minute Rule. The proposed MPPR policy expansion is yet another uncomplimentary control to the former, and more importantly, is continuing to drive the ability to provide professional care away from the expertise and discretion from professionals and towards regulatory agencies.

Additionally, as providers have been moving towards more efficient care delivery, a central theme to reform legislation, the focus has been toward improving patient care access and convenience. Many providers have increased availability of service during early morning hours, noon-time, evenings, and weekends to increase beneficiary convenience while reducing redundancy and frequency of visits necessary for an optimal beneficiary experience and outcome of care. This has been possible through an integrated focus of care planning, ongoing communications, and streamlined / automated documentation systems in a coordinated fashion that is seamless for the beneficiary. Reform legislation has emphasized all of these elements as vital to reduce the costs of health care. NARA is convinced that the MPPR policy as provided to rehabilitation providers will foster operational models that unnecessarily impact efficient and effective care by fragmenting provider organizations / entities and actual professionals in coordinating care because reimbursement will be aligned with those treating beneficiaries on a “first come – first serve” basis within a given day. Given these dynamics, the focus and emphasis is not aligned with, and, indeed is antithetical to optimal care outcomes.

The MPPR Policy Will Adversely Impact Access to Care

The steady and forecasted demographic shifts indicating significant increase in the senior population and need for professional rehabilitation therapy care to support an optimal active aging process as well as treatment of acute and chronic disease and conditions require the support of a challenged industry. Implementation of the MPPR would likely result in one of the following:

1. *Reduction / Elimination of Services*
2. *Decision to Not See Beneficiaries*
3. *Closing of Practices / Providers*

The inevitable combination of the above consequences will reduce access to service of the fastest growing segment of our population as well as adversely impact well intended focus on wellness, prevention, and disease / conditions management models.

The MPPR Policy Will Jeopardize the Sustainability of Rehabilitation Providers

NARA is proud of its membership representing nearly 70 rehabilitation therapy service organizations of various sizes which employ over 15,000 professionals and care givers as well as thousands of additional employees. Implementation of the MPPR model and the subsequent deleterious impact on clinical and business models and on patient access to care would materially jeopardize businesses that are already financially challenged. NARA's providers are businesses and employers, many of which have been well established for decades that support rural and urban communities through the employment of professional and support staff. The consequences of implementation of a policy that is not well thought out will be significant to both clinical and business models, further exacerbating issues facing our nation's economy such as rising unemployment, the uninsured, and deteriorating local level economies and tax contributors.

NARA also endorses fully the technical comments on this proposed rule provided by the American Physical therapy Association.

For the reasons set out above, NARA urges CMS not to adopt the MPPR policy extension to outpatient therapy services.

Respectfully Submitted,

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