



National Association for the  
Support of Long Term Care

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## National Association for the Support of Long Term Care

June 22, 2013

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

The Honorable Ron Wyden  
Ranking Member, Senate Finance Committee  
U. S. Senate  
Washington, DC 20510

The Honorable Johnny Isakson  
Co-Chair, Chronic Care Working Group  
U.S. Senate  
Washington, DC 20510

The Honorable Mark Warner  
Co-Chair, Chronic Care Working Group  
U.S. Senate  
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner:

The National Association for the Support of Long Term Care (NASL) is pleased to submit these comments to the Senate Committee on Finance chronic care working group in response to the Committee's May 22 letter soliciting recommendations on policies that will improve care for Medicare beneficiaries with chronic diseases.

NASL is a national trade association representing providers and suppliers of ancillary services to long term and post-acute care (LTPAC) settings. NASL's members include rehabilitation therapy providers that employ physical therapists, occupational therapists and speech-language pathologists who provide therapy services to patients in nursing facilities as well as other long term and post-acute care settings. In addition, NASL represents developers of health information technology (HIT) with full clinical and point-of-care IT systems, suppliers of durable medical equipment, clinical labs and portable x-ray services. Thus, NASL members have extensive and longstanding experience with the chronic care population, which largely makes up those we treat in skilled nursing and long term care facilities. Our comments focus on the definition of stronger patient outcomes; the expansion of Medicare coverage of telehealth to include rehabilitation services; and health information technology.

### Definition of "Stronger Patient Outcomes"

NASL commends the Committee for proposing to evaluate each policy to see if it "facilitates the delivery of high quality care, improves care transitions, produces stronger patient outcomes, increases program efficiency, and contributes to an overall effort that will reduce the growth in Medicare spending." However, we caution the Committee to carefully consider how it will define "stronger patient outcomes."

The *Jimmo v. Sebelius* settlement agreement clarifies that Medicare coverage cannot be denied in instances where a beneficiary requires skilled services to prevent or slow further deterioration even if there is no potential for improvement or restoration. For example, individuals with degenerative diseases may require therapy services to maintain function even though they may not experience significant functional gains or improvements as a result of the services. These skilled services can help

patients avoid further deterioration, and as a result may ultimately save money. Thus, we urge Congress to avoid requiring improvement or restoration when defining “stronger patient outcomes.”

#### Expansion of Telehealth to Include Rehabilitation Services

NASL commends the Committee for considering telehealth and remote monitoring as part of its chronic care reform efforts. NASL is actively engaged in the pursuit of policies related to the advancement of HIT and telehealth. Telehealth technology is a clinically-effective, cost-effective mechanism that increases Medicare beneficiaries’ access to needed services and providers. NASL believes that current Medicare policy related to telehealth services is far too limited, and as a result hinders beneficiaries’ access to needed services.

This is not a speculative or future concept. Current telehealth technology is a viable addition to standard therapy practices. Thus, we believe that the Committee’s chronic care reform efforts should include the meaningful expansion of Medicare’s telehealth program by:

- Expanding the categories of telehealth services that may be covered by Medicare;
- Increasing the list of health care providers who may furnish Medicare’s telehealth services;
- Expanding the sites that may be “originating sites” beyond rural counties and health shortage areas in metropolitan areas; and
- Providing for Medicare coverage of home-based telehealth services, including rehabilitation therapy services.

Specifically, NASL urges Congress to provide Medicare beneficiaries with timely access to rehabilitation therapy by expanding Medicare coverage of telehealth services to include physical therapy, occupational therapy, and speech language pathology services. We believe that Congress should define covered providers for the purposes of rehabilitation therapy telehealth services to include physical therapists, occupational therapists and speech-language pathologists, as well as physical therapist assistants and certified occupational therapy assistants.

We wish to highlight one example where telehealth is being used successfully to bolster patient access to care, and how NASL members collaborated with the State of Washington and a community-based therapy provider on a tele-rehabilitation pilot project. The pilot sought to overcome significant barriers to patients’ timely access to physical therapy due to a combination of state requirements regarding supervision of physical therapist assistants (PTAs) and the limited number of qualified physical therapists working in rural areas of the state. The proposed pilot required a minimal investment in approved telehealth equipment. Working with the State and community partners, NASL members involved in the pilot delivered on more than their goals to improve clinical outcomes and patient access. The pilot demonstrated that telehealth could be used to bridge the gap between limited workforce resources and patient need in rural areas. On both the provider side as well as the health care system, better clinical outcomes led to faster discharge and less change of re-hospitalization. The State has since amended the Washington Administrative Code to include the use of telehealth in the practice of physical therapy (WAC 246-915-187).

### Health Information Technology

NASL urges Congress to consider how health information technology (HIT) can be used and encouraged in coordinating care across settings, including post-acute care. We strongly believe that HIT is essential to the ultimate success of health reform models and efforts to coordinate care among different providers. Our IT vendor companies serve the majority of LTPAC providers. NASL is a founding member of the Long Term & Post-Acute Care Health Information Technology Collaborative (LTPAC HIT Collaborative), which formed in 2005 to advance HIT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.

NASL and its membership are strong advocates for HIT, information exchange through interoperability and electronic health record (EHR) adoption. Our members have been involved in Health Information Exchange (HIE) Challenge Grants and the Standards & Interoperability (S&I) Framework. NASL members also participate with Health Level Seven International (HL7) and the National Council for Prescription Drug Programs (NCPDP), both of which are ANSI-accredited standards developing organizations (SDOs). We are proud to note that – even though LTPAC providers are not eligible for EHR incentives under Meaningful Use – several NASL member companies have developed software products that have been certified and are listed on the Certified Health IT Product List (CHPL) maintained by the Office of the National Coordinator for Health Information Technology (ONC).

Typically, LTPAC patients are frail, have multiple co-morbidities and are unable to manage their own care. Often, these patients rely on a variety of providers and care settings – each of which may use different EHRs – to tend to various aspects of their care. Thus, innovation in developing and customizing HIT products and systems uniquely tailored to the special needs of LTPAC patients and the care environment is critically important.

Although HIT and health information exchange may be valuable in coordinating care, a complicating factor is that not all settings are alike – nor are the tools that are needed in caring for the unique needs of our patients. Congress clearly understood that in enacting the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (Pub. L. 113-185)*. That effort – and the aggressive timeline for implementation that Congress established for the *IMPACT Act* – is driving greater collaboration among LTPAC stakeholders, CMS and ONC. NASL urges Congress to align the efforts of the chronic care working group with the *IMPACT Act* and other laws impacting HIT, and to recognize that HIT has been adopted and implemented differently in various settings of care due to different incentives and the applicability of meaningful use and certification criteria.

Chronic care spans the continuum and therefore is not limited to solely institutional care or care in the home. The *IMPACT Act* is bringing down silos between post-acute care settings and efforts to address chronic care must not unintentionally build silos. Care for those with complex chronic conditions must be longitudinal and take into account social services may be needed in addition to medical services.

Importantly, LTPAC, behavioral health and other providers did not benefit from the incentives provided for in the *Health Information Technology for Economic & Clinical Health (HITECH) Act*. Certainly, it is that lack of incentives – and not a lack of interest in EHR adoption, use and health

information exchange – that is a contributing factor for the lower health IT adoption rate among LTPAC providers to date. We urge Congress to establish care coordination policies that facilitate participation by a broad range of LTPAC providers, including those who do not currently have HIT.

Additionally, NASL believes that the development, use of and adherence to standards are fundamental to successful HIT, health information exchange and HIT interoperability, which are critical to care coordination. All stakeholders need to begin with a common language, i.e., the terminology that clinical experts agree on, and understand how that language is used. These technical standards will allow for interoperability across care settings. Much work is already occurring on long term services and supports through CMS and ONC efforts on information exchange. We believe that fostering a culture where clinicians in every setting value and use data from other settings would go a long way toward driving standards, greater interoperability and care coordination across settings.

Thus, we believe that it is imperative for Congress to consult with stakeholders that serve the LTPAC community when incorporating HIT into any care coordination initiative. In addition to understanding the unique challenges of HIT and health information exchange in the LTPAC settings, LTPAC vendors can assist Congress with understanding the realities of development timelines.

We have one additional point on this issue. Changing HIT programs and systems takes time and considerable resources. The burdens placed on providers to ramp up their operations so that they can participate successfully in these models and programs can be overwhelming. Vendors can implement changes under compressed timelines, but warn that limiting the IT development timeline has consequences and increases the risk of failure on some level. LTPAC vendors state that anything less than 90 days increases the likelihood that changes could go awry. In the past, NASL member companies that provide software solutions for the majority of LTPAC providers have had to set aside industry best practices and work aggressively to implement changes such as the FY2014 MDS 3.0 data submission specifications in considerably less than 60 days. We urge Congress to move forward in a way that reflects these burdens and avoids compromising on best practices.

#### Three-day prior hospitalization rule

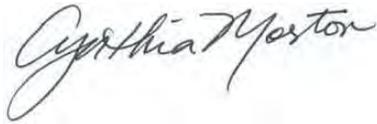
Many commentators on health reform have expressed the need to remove certain regulatory requirements that may hinder providers' ability to provide the right care in the right setting at the right time. The three-day prior hospitalization rule as a predicate for skilled nursing facility care under Part A is perhaps the best example of this. It appears, however, that this policy finally may be on the table for change.

The recently issued final rule on the Medicare shared savings program will enable accountable care organizations to apply for a waiver of this rule in 2017. A principal basis for granting such waivers will be a required showing that the care provided to the SNF residents will be clinically integrated across sites of care. We believe that this would be consistent with the Finance Committee's exploration of how best to ensure coordinated care for chronically ill individuals – the alignment of policies with providers' ability to provide the appropriate care, upon a showing that the care will be coordinated among the various providers involved with the particular patient. We urge the Committee to consider

eradicating the three-day hospitalization requirement or permitting waivers to it as reflected in the Medicare shared savings rule.

NASL looks forward to continuing to work with the Senate Finance Committee on chronic care and better coordination and services for this important population. If you have any questions or need additional information, please contact me at [Cynthia@nasl.org](mailto:Cynthia@nasl.org) or 202 803-2385.

Sincerely,

A handwritten signature in cursive script that reads "Cynthia Morton". The signature is written in black ink and is positioned above the typed name and title.

Cynthia Morton  
Executive Vice President