Salary Equivalency Guidelines

Issue: Christina Metzler of the American Occupational Therapy Association, Inc. is expressing concern over the prescriptive language in the provision establishing salary equivalency guidelines in the President's Medicare reform package. She recommends substitute language that states that the data "be appropriate to determining payment..."

Response:

- Salary equivalency guidelines currently exist for physical therapy and respiratory therapy services. Guidelines for these services were last revised in 1983. The guideline amounts have been updated for inflation. Although the Secretary already has broad statutory authority to establish salary equivalency guidelines, the legislative proposal requires the Secretary to update the guidelines for physical and respiratory therapy, and establish new guidelines for occupational therapy and speech language pathology services.

- In a recent report, the GAO documented widespread examples of overcharges to Medicare for therapy services, and recommended that HCFA establish therapy guidelines for services currently not covered by such guidelines to prevent such abuse.

- Although the Secretary currently has the ability to establish therapy guidelines under current rulemaking authority, the legislative proposal provides a more immediate response to the abuses that have been documented by GAO.

- The methodology in the legislative proposal calls for using the 1983 methodology, which uses Bureau of Labor Statistics data with an add-on to reflect differences in setting. This is the best data currently available. However, the legislative proposal allows the Secretary to substitute other data if she determines such data to be equally valid. Thus, the legislative proposal does not preclude the use of industry data in updating the guidelines, should HCFA find that data to be accurate and adequate.

- **The legislative route allows the savings to be counted in the current budget debate. Savings cannot be scored unless the legislation establishes the specific guideline amounts or provides a prescriptive methodology. Thus, more general language, such as Ms. Metzler has suggested, cannot be substituted.**

AOTA The American Occupational Therapy Association, Inc.

January 31, 1996

Bruce Vladeck, Ph. D.
Administrator
Health Care Financing Administration
Hubert Humphrey Building 314G
200 Independence Avenue SW
Washington, DC 20201

Dear Dr. Vladeck:

At the White House briefing on health care on Thursday, January 25, I spoke with you briefly about the language in the President's most recent budget proposal regarding salary equivalency guidelines for therapy services (Title XI, Sec. 11114 in the December draft).

As I mentioned to you this language is very prescriptive and would appear to be much more specific than appropriate for legislative language. You agreed to review and consider this language.

AOTA would like to strongly suggest that specific language in the draft in the sections on the calculation of amounts and data should be eliminated. We believe that including such specifics in legislation is unnecessary in light of current law which gives the agency flexibility through the use of the regulatory process. Current law in Sec. 1861(v)(1) states that reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs...."

We believe the rulemaking process provides the Secretary with the appropriate mechanisms for accurately and appropriately determining reasonable cost. Indeed the proposed language fails to address some of the areas which the agency has indicated in existing regulation are important to this issue.

We recommend that for any present budget legislation, if salary equivalency is to be addressed, language should be substituted which simply states that the data used to compute the formula will be appropriate to determining payment for services provided in specific settings; timely with regard to economic and other factors; and accurate.

Such an approach would give the agency full flexibility for determining an appropriate methodology and would allow for the open and appropriate use of the regulatory process to finalize the data components and computation with adequate input from all stakeholders.

This would prevent the law from becoming obsolete and would give the agency more flexibility with regard to using the best possible sources and elements of data to determine reasonable costs.

We urge you to review and modify this language in the President's budget proposal and thank you for your consideration.

Sincerely,

Christina A. Metzler
Senior Legislative Representative
Government Relations Department

CAM/bp

cc: Cybele Bjorklund, Office of Senator Daschle
Jennifer Klein, Office of the President, Domestic Policy
Courtenay McKinnon, Office of Representative L. F. Payne

SNF Reimbursement

House Bill HR 2425	Democrat Ways & Means	Democratic Coalition	Senate
Routine costs: cost limits freeze extended	Prospective Payment/routine costs October 1, 1996 112% of mean per diem	*Same as HR 2425*	Prospective Payment on or after October 1, 1997 for all costs
Non-routine costs limits based on formula →50% national →50% facility	Hospital based?		Interim (FY96/97) Routine costs redefined (supplies and equipment)
50% Rebate of savings achieved	Prospective Payment/all costs October 1, 1998 5% reduction per year of what otherwise would have been spent		RCL freeze continued exceptions must be budget neutral
SNF must bill for all Part B services, before and after 100 day Part A coverage	Maintain RCLs Freeze		Capital cost reduced by 15%
Exceptions for a typical case limited to 5% of aggregate expenditures for all	7 year savings $6.1 billion		Non-routine/ancillary services limited in growth, base year FY93/94
Special rates for high intensity nursing, rehabilitation patients to be established			Retroactive salary limits for therapies
7 year savings $10.4 billion			Special rate for high intensity nursing and rehabilitation but must be budget neutral and paid from non-routine/ancillary base
			Part B services billed by SNFs and reduced by 5.8%
			Secretary can reduce payments at any time
			7 year savings $10.4 billion

Look into this.

OT Week
November 11, 1993

Q & A's About Medicare Salary Equivalency Guidelines

What is the Medicare rule concerning payment for "therapy services under arrangements" (i.e., salary equivalency guidelines)?

In 1975, the Health Care Financing Administration (HCFA) issued a regulation (42 CFR 413.106) that defines the "reasonable cost of therapy and other services furnished under arrangements" (i.e., under a contractual arrangement). This regulation states that "the basis for determining the reasonable cost of therapy services rendered for providers by outside suppliers is limited to amounts equal to the salary and other costs that would have been incurred by the provider if the services had been performed in an employment relationship, plus an allowance to compensate for other costs an individual not working as an employee might incur in rendering services under arrangements.

"The cost of therapy service furnished by outside suppliers is evaluated in terms of the actual cost incurred by the provider in comparison with the prevailing hourly salary paid full-time therapists employed by providers in the area. The prevailing salary is the hourly salary rate based on the 75th percentile of the range of salaries, by type of therapy, paid by providers in the geographical area. The fringe benefit and expense factor is an allowance that compensates an outside supplier not only for fringe benefits, but also for the expenses of a nonemployed therapist, i.e., expenses such as office space, telephone, bookkeeping, and billing. The adjusted hourly salary equivalency amount is the prevailing hourly salary rate plus the fringe benefit and expense factor. This amount is determined on a periodic basis by geographical area.

"A standard travel allowance equals one-half of the applicable adjusted hourly salary equivalency amount. One standard travel allowance is recognized for each day an outside supplier performs skilled services at a provider site. The guidelines reflect the application of the prevailing salary, the fringe benefit and expense factor, the adjusted hourly salary equivalency amount and the standard travel allowance to an individual therapy or other health-related service and a geographical area."

What types of Medicare providers are subject to these rules for what kinds of services?

The rules on "salary equivalency" apply to all services (other than physician) furnished by an outside supplier to a hospital (except inpatient services paid under DRG rates), skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency. Although HCFA has had the authority to implement this regulation for a wide range of services, up to this time, the agency has issued specific dollar limitations only for physical therapy and respiratory therapy services.

Why should OT practitioners be concerned about this rule now?

In August, the HCFA Atlanta regional office (region IV) sent a memo to all intermediaries in their states requiring them to apply Medicare "salary equivalency guidelines" to the contract occupational therapy and speech-language pathology costs incurred by nursing facilities. This instruction was in response to alleged billing of "exorbitant rates" for contracted rehabilitation services, which were then passed to the Medicare program through the nursing facilities cost report. The region also provided a list of "salary equivalency amounts" to be used in reviewing "all unsettled cost reports and all cost reports that are still subject to reopening." These amounts were based on a formula derived from home health agency cost limits and physical therapy salary equivalency guidelines.

AOTA believes that the HCFA regional office (1) had no authority to issue policy based on this regulation, (2) did not follow the regulation requirements for computing the "salary equivalency amounts," and (3) illegally attempted to apply the "guidelines" retroactively to nursing facility cost reports.

What is AOTA's position and what has the association done so far to respond to HCFA?

AOTA recognizes and strongly supports HCFA's attempts to protect the integrity of the Medicare program by issuing national guidelines. The association, however, is also concerned that the policy directives balance program cost containment measures with the assurance of continued quality services to Medicare patients. Also, we believe that in setting appropriate guideline amounts, HCFA must use the most current, valid data available and must consider updated cost variables (e.g., the effects of the hospital prospective payment system on post-hospital rehabilitation ser-

vices, widespread staffing shortages).

Immediately after the HCFA regional office memorandum was distributed, AOTA staff spoke to the regional office, the intermediary, and HCFA central office expressing our objections. We also have monitored the efforts of the rehabilitation agency groups in delaying the implementation of the Atlanta region directive. On Sept. 30, AOTA executive director, Jeanette Bair, MBA, OTR, FAOTA, wrote to Bruce Vladeck, the HCFA administrator, to formally communicate our concerns about the regional policy and to offer AOTA's assistance to HCFA in obtaining appropriate salary, fringe benefit and other required data.

What is happening now on the salary equivalency issue?

We have been informed that HCFA plans to promulgate a notice of proposed rule making in accordance with the regulatory requirements with salary equivalency dollar amounts for occupational therapy and speech-language pathology by July 1994. This rule-making procedure provides for a 60-day comment period and a prospective implementation. Staff from AOTA and the American Speech-Language-Hearing Association have requested a meeting with HCFA staff responsible for implementing this regulation to discuss data sources and the proposed methodology.

In addition, HCFA plans to instruct intermediaries to apply a "prudent buyer analysis" to determine the reasonableness of occupational therapy and speech-language pathology costs under arrangement in settling Medicare cost reports. The "prudent buyer" provision states that a provider of service should not pay more than what other providers in the same area pay for the same service, and that if a provider does, Medicare should not reimburse more than the going rate. Intermediaries (insurance companies that pay Medicare claims) have always had the authority to apply this concept to costs that are "out of line." In other words, intermediaries can disallow costs if they show that a provider (e.g., nursing home, HHA) is buying services or products at inflated prices.

What should individual OTs do?

Be informed. Understand the reasons and the rules governing the "prudent buyer" and "salary equivalency guidelines." By knowing the facts and disregarding the rumors, you will be prepared to support the profession when questions arise in your facility or when commenting on the proposed rule.

The pertinent information can be found in the following references:

Therapy services furnished under arrangement:

Code of Federal Regulations (42 CFR 413.106)

Medicare Provider Reimbursement Manual (HCFA-Pub. 15, chapter 14)

Prudent Buyer Principle:

Medicare Provider Reimbursement Manual (HCFA-Pub. 15, section 2103)

The Code of Federal Regulations is available in most public libraries and all Medicare providers should have copies of HCFA-Pub. 15 for reference.

AOTA members may obtain copies of these sections for $7 ($10 for nonmembers) from AOTA's products department, order #1800. Call 1-800-SAY-AOTA (members); or (301) 948-9626 (nonmembers).

AOTA The American Occupational Therapy Association, Inc.

September 27, 1995

The Honorable William Archer
Chairman
Ways and Means Committee
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am writing to you to express AOTA's serious concerns about elements of the Medicare budget reconciliation proposal which will come before the Ways and Means Committee.

AOTA represents 52,000 occupational therapy practitioners, a substantial proportion of whom work with Medicare beneficiaries in hospitals, home health agencies, rehabilitation hospitals and agencies, skilled nursing facilities, outpatient clinics and other settings. As the professional association representing occupational therapy practitioners we are committed to the provision of those services by properly trained professionals and to assuring that those professionals are able to practice within an ethical framework which serves the best interests of patients.

Although we have not been privy to legislative language details, the information we have had thus far forces us to express serious apprehension about the potential impact on patient care of the proposals to implement prospective payment systems for home health and skilled nursing facility services under Medicare.

While we agree that changes in the methods Medicare uses to pay for services can be improved, we believe these proposals, as we understand them, have major flaws:

- The prospective payment systems being proposed for home health agencies (HHAs) and skilled nursing facility services (SNFs) are scheduled to be implemented over the next two years while the methodology for implementation is not yet well developed and refined. Implementation should be scheduled on a more realistic timetable which allows for research and testing of both cost impact and effects on patient care.

- While AOTA supports moving in the direction of restructuring payment systems for services provided by SNFs and HHAs, use of inappropriate and flawed interim regulatory measures such as salary equivalency may deter or skew the development of broader, more comprehensive methods of reform.

- Cost limits for SNF ancillary services are envisioned to be built on a combination of a national average and a facility average. AOTA believes that using only these two factors is inadequate. Prospective payment systems must not be built on ill-designed caps which apply to facilities; rather, they should be built based on patient needs and characteristics. The home health prospective payment system is scheduled to use patient classification categories, but the skilled nursing facility system is proposed to be based only on facility costs. In addition, we have concerns that the SNF ancillary cost limits will prohibit providers from effectively serving high need patients.

- Offering financial inducements or rewards to providers based on how much they save below a cost limit is a prescription for underservice and denial of patient care. Incentives for savings should not take precedence over incentives to provide appropriate care. The use of savings bonuses to providers to encourage savings does so at the expense of patients. While appropriate incentives could be used to promote cost effective care, a conservative approach, carefully implemented and monitored, must be used.

- No desired or expected patient outcomes for either home health or skilled nursing care are mentioned as part of the overall approach to improve the payment system. Cost effectiveness improvements must be linked to patient outcomes. Episodes of care or levels of reimbursement must be designed with quality care and achievement of optimal health and functional outcomes as paramount objectives.

- No quality monitoring mechanisms or expectations are outlined to assure that funds are equitably allotted to patients based on patient need and establishment of desired patient outcomes. Control and monitoring of quality of care and patient outcomes are not inconsistent with prospective payment; indeed if a system is built based on identified patient need, more cost effective services will be provided.

Changes can be made to the current systems which can improve ability to monitor and control costs but it would be short-sighted to do so at the expense of patient health, well-being, and function. SNF and HHA patients receive services to recover and to prepare to return to more independent functioning. If they recover inadequately or are denied services which can assure recovery or a safe return home, they may require further hospitalization or SNF care.

We support moving in the direction of broad and fundamental reform of the payment system for these services but must recommend that the Committee reconsider the design and timetable proposed.

AOTA believes that any prospective payment policy for Medicare post-acute services must be based on a patient classification system that fully reflects the professional and facility resources required to achieve optimal patient outcomes. Such a system has not been developed sufficiently to allow implementation of prospective payment on the short timetable envisioned. Experience to date with patient classification systems for the post-acute patient have shown that diagnosis alone is not sufficient -- patient functional status provides a critical dimension of the care that will be required. Varying service needs and duration of need must

also be considered. Providing for the proper type and intensity of therapy services is key to avoiding subsequent costs and we believe requires further development and pilot testing.

We would welcome the opportunity to work with you and the Committee to achieve the goal of improving Medicare services and payment. Please do not hesitate to contact us.

Sincerely,

Frederick P. Somers
Director
Government Relations Department

cc: Members of the Committee

December 1, 1995

The Honorable William Roth
United States Senate
104 Senate Hart
Washington, DC 20510

Dear Senator Roth:

We are very concerned about the adverse effects of several provisions of the Balanced Budget Act which undermine care and services for Medicare beneficiaries in the nursing home setting, especially those who need heavy intensity services. We urge your assistance in reducing the impact on skilled nursing facilities and to work with us in modifying the legislative proposals, at a minimum by eliminating the following provisions as a top priority:

- Capping payments for non-routine SNF patient services (i.e. rehabilitation therapies and other ancillary services) under section 8412.

- Capping Medicare spending for SNF routine cost limit exceptions under section 8413(d).

These provisions strike at the heart of the Medicare SNF benefit. They would reverse the significant progress made in recent years, much as a result of Congressional action, to improve the quality and comprehensiveness of SNF services and to accomodate "sicker" patients and provide a more cost-effective alternative to routine hospital care. People recovering from a stroke or hip fracture are prime examples of those who would be hurt if these provisions are enacted.

The primary approach to containing SNF costs should be the establishment of a prospective payment system, as expressed in the Act, to be implemented as soon as possible. A prospective payment system designed to consider patient acuity, desired health and functional outcomes, and emerging technologies, will efficiently control growth in spending and allow for improved predictability in this critical area of the Medicare program. In addition, savings will be achieved from maintenance of the savings from the FY 94-95 routine cost limit freeze. Taken together these two elements alone would provide considerable cost savings without disrupting services to Medicare beneficiaries.

Our biggest concerns are that as drafted the legislation disrupts services to patients with higher acuity and destroys the development of cost effective subacute care programs. A transition to a prospective payment system should not be done in this fashion. This is bad public policy.

We look forward to working with you on alternative solutions.

American Association for Respiratory Care
American Occupational Therapy Association

American Pharmaceutical Services
American Physical Therapy Association
American Society of Consultant Pharmacists
American Speech-Language-Hearing Association
Beth Abraham Hospital
Golden Care, Inc.
Integrated Health Services, Inc.
Living Centers of America
Mariner Health
Metropolitan Jewish Geriatric Center
National Alliance for Infusion Therapy
National Association for the Support of Long Term Care
National Association of Chain Drug Stores
National Association of Rehabilitation Agencies
National Subacute Care Association
NovaCare, Inc.
The Jewish Home & Hospital for Aged
The Parker Jewish Geriatric Institute
United Health, Inc.

November 10, 1995

«Title» «First» «Last»
«address»
«city» «st», «zip»

Dear «Title» «Last»:

We, the undersigned organizations, wrote to you recently to express our unified concern over Medicare budget proposals affecting rehabilitation therapy and other non-routine services provided to patients in skilled nursing facilities. As we pointed out in our earlier letter, severe restrictions on reimbursement for rehabilitation therapy, pharmaceuticals and other non-routine services would have a serious negative impact on the very sick patients that require such services.

We remain very concerned about the impact of these proposals on patient care and ask that you make the following changes in SNF budget proposals in conference in order to address this problem:

1. Adopt the Senate provision to establish a prospective payment system by FY 1998

2. Make changes in Senate provisions for FY 1996-1997. It is important that spending controls on ancillary and related services (1) should not be applied retroactively and (2) should "hold harmless" current services. In the current proposals, there are some provisions which would impose controls back to October 1, 1995. Furthermore, there are some provisions which would use an unnecessarily "old" base period, thus penalizing providers who have served an increasingly high proportion of high-need patients.

NON-ROUTINE SERVICES REIMBURSEMENT CAP.
The cap should not be retroactive and should "hold harmless" existing providers and services.

- Change the base year for calculating the cap to the 12 month period ending September 30, 1995.

- Implement the cap at some date after enactment of legislation.

- The rate for patients with intensive nursing or therapy needs should apply when the cap goes into effect, not at some later date.

- Ancillary services experts as well as skilled nursing experts should be consulted in developing the intensive need rate.

ROUTINE COST LIMIT EXCEPTIONS CAP
As above, the cap should not be retroactive and should "hold harmless" existing providers and services.

- Change the base year for determining the cap from FY 1994 to FY 1995.

- Implement the cap at some date after enactment of the legislation.

SALARY EQUIVALENCY

- Eliminate entire provision which is retroactive

MANDATORY CONSOLIDATED BILLING FOR PART B STAYS

- Eliminate provision which does not result in any budgetary savings and is not necessary to collect data to establish PPS.

In addition to the above changes, the following provisions require clarification:

5.8% REDUCTION IN PAYMENTS FOR PART B SERVICES.

- What is the intent of this provision and how would it be applied?

DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNT.

- Dividing total payments by the average number of days per stay for all residents is not logical. Should (2) read "the number of part A stays"?

NON-ROUTINE REIMBURSEMENT RATE FOR HIGH INTENSITY PATIENTS

- We assume that the rate applies only to the reimbursement of non-routine services. Why nursing, a routine service, referred to in this section? Is the intent to include non-routine medical services.

Thank you for your consideration in addressing these important issues affecting patient care.

Sincerely,

Abraham Hospital	American Assn. for Respiratory Care	Amer. Occupational Therapy Assn.
American Pharmaceutical Services	Amer. Society of Consultant Pharmacists	Amer. Speech-Language-Hearing Assn
Avante, Inc.	EFS Healthcare	Golden Care, Inc.
Health Care and Retirement Corp	Health Industry Distributors Assn.	Hillhaven/Vencor
Horizon	Integrated Health Services	KCI
Living Centers of America	Mariner	Metro. Jewish Geriatric Center
Nat'l Alliance for Infusion Therapy	National Assn of Rehab Agencies	Nat'l Assn for Support of Long Term Care
National Subacute Care Assn	Nova Care	Parker Jewish Geriatric Institute
TheraCare Rehab, Inc.	United Health, Inc.	

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NovaCare

John H. Foster
Chairman

December 13, 1995

The Honorable
William J. Clinton
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

I was really surprised and disappointed that your Medicare reform package contained detailed instructions for calculating therapy reimbursement guidelines that refer to outdated and inappropriate data. You should be aware the proposed text locks in place a formula which is seriously challenged by leaders of the rehabilitation and nursing home sectors.

At issue is not whether there should be salary equivalency guidelines, but whether such rules should be based on timely, accurate and relevant data. The provider sector has questioned the application of outdated hospital salary data in calculating the guidelines which are primarily applied in the nursing home and home care settings. The Secretary is aware there is a privately funded study nearly completed which will provide to HCFA more appropriate data to be used in rule-making. Obviously, the text of the Medicare proposal puts at question our efforts at collecting accurate data.

Obviously, I am disappointed that this proposal was advanced with little or no consultation with those of us who initially raised this matter to your attention. Hopefully, with your help, we can clarify and simplify the legislative text giving direction that final rules be based on "timely, accurate and relevant data."

With warm personal regards,

John H. Foster

NovaCare Inc 1016 West Ninth Avenue King of Prussia, Pennsylvania 19406 215 992 7400 FAX 215 992 3330

SALARY EQUIVALENCY GUIDELINES FOR THERAPY SERVICES

Section 1861(v)(5) (42 U.S.C. §1395x(v)(5)) is amended--

(1) By redesignating subparagraph (B) as subparagraph (C),

(2) In subparagraph (C), as redesignated, by adding "or (B)," after "Subparagraph (A),",

(3) by inserting the following after subparagraph (A):

"(B) No later than _____, The Secretary shall re-issue payment guidelines for physical therapy and respiratory therapy, and develop new payment guidelines for speech-language therapy and occupational therapy which shall be based on timely and accurate data relevant to the particular types of providers subject to the guidelines and result in an aggregate of $1.4 billion in savings to the Program from fiscal year 1996 through fiscal year 2002."