

MEMORANDUM

To: Coalition to Preserve Rehabilitation Members
From: Peter Thomas and Joe Nahra, Coordinators of CPR
Date: January 25, 2020
Re: Coalition to Preserve Rehabilitation Year in Review 2020

Executive Summary

We write to provide you with an update on the activities of the Coalition to Preserve Rehabilitation (CPR) in 2020. As we enter 2021, we want to provide a summary of advocacy efforts made on behalf of CPR and its member organizations over the past twelve months.

CPR's strength as a representative coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative services in all settings is evident through its active and productive portfolio of advocacy efforts. Despite the upheaval associated with the COVID-19 pandemic, this past year was no exception, as CPR engaged with policymakers and federal agencies to advance its targeted agenda. This memorandum summarizes CPR's work across a number of key priorities in 2020. Further information on CPR's activities, as well as our advocacy archives, can be found on the [CPR website](#). We encourage CPR members to review this memo and consider any suggestions for continued or new policy priorities for the Coalition's 2021 efforts to discuss at the upcoming All-Member meeting, to be held on **Tuesday, January 26, from 12:30-2pm ET**. For more information or questions about the Coalition, please contact Joe Nahra at Joseph.Nahra@PowersLaw.com.

2020 Advocacy Highlights

In 2020, CPR engaged with Congress, the Trump Administration, and external stakeholders on a variety of key priority issues for the Coalition. These addressed CPR's stated priorities, which can be found here, as well as additional advocacy efforts to advance the goal of increased access to rehabilitation care for people with disabilities, illnesses, and chronic conditions. Our advocacy efforts included a significant number of proposals directed at the COVID-19 response from a rehabilitation perspective. While many of these activities centered around regulatory action, CPR also engaged in a variety of legislative initiatives. These efforts are summarized below.

1. Inpatient Rehabilitation Facility Prospective Payment System

In June, the CPR Steering Committee submitted [comments](#) on the proposed Fiscal Year (FY) 2021 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) rule. CPR's comments focused on the role of non-physician practitioners in IRFs and on documentation requirements

impacting patient access to rehabilitation. CPR did not comment on the annual payment rate updates for IRFs and the revised relative weights for IRF case-mix groups.

a. Role of Rehabilitation Physicians in IRFs

In the rule, the Centers for Medicare and Medicaid Services (CMS) proposed to expand the scope of the IRF coverage requirements to allow non-physician practitioners (NPPs) to perform many duties currently required to be performed by a rehabilitation physician, including conducting the preadmission screening and post-admission physician evaluation, lead weekly team meetings, conduct patient face-to-face meetings, and develop patients' plans of care. Understanding the important role that NPPs play in rehabilitation and the broader health care system, the Steering Committee strongly opposed the proposal on the grounds that it could undercut IRF care and decrease the level and quality of care provided in an IRF, with a significant potential impact on care for patients with complex conditions who require the intensive, coordinated treatment provided by IRFs.

In response to stakeholder comments, CMS rescinded the majority of the proposal to expand the role of NPPs in IRFs when it issued the [final rule](#) in August. Instead, CMS finalized a provision allowing an NPP to conduct one of the three weekly required face-to-face visits for an IRF patient after the first week of admission. The Steering Committee supported this change to ensure that the role of physicians with expertise and experience in rehabilitation is maintained as the leaders of the interdisciplinary rehabilitation teams.

b. Additional IRF Coverage and Payment Policies

CMS also proposed revisions to some of the documentation requirements in IRFs. Specifically, the agency proposed to eliminate the post-admission physician evaluation (PAPE) as a requirement to justify an IRF admission, noting that much of the information contained in the PAPE is duplicative of information collected at other stages of the admission process, including the preadmission screening (PAS). The Steering Committee supported this proposal, and urged CMS to retire the PAS as well, instead suggesting a broader rethinking of the IRF documentation requirements to allow for a complete and thorough examination by a trained rehabilitation physician and an analysis of the patient's history and physical focused on the need for intensive rehabilitation care.

CMS finalized the proposal to remove the PAPE, which is no longer required to document medical necessity in an IRF.

2. Skilled Nursing Facility Prospective Payment System

In June, the CPR Steering Committee submitted [comments](#) on the proposed FY 2021 Skilled Nursing Facility (SNF) PPS rule. The letter reiterated CPR's concerns with the impact of the so-called Patient-Driven Payment Model (PDPM), which was implemented in the SNF PPS in October 2019. CPR has noted that the PDPM structure may incentivize facilities to decrease or even refrain from providing therapy to patients in SNFs due to the design of the new case-mix classification

model. CPR's comments noted several troubling indicators, including reports from therapists of increased group and concurrent therapy over individualized therapy, often mandated by SNFs, and significant reductions in therapy staff in SNFs across the country. CPR urged CMS to collect and publicly report expanded data on therapy utilization, patient characteristics and outcomes, and other relevant information on the implementation of the PDPM to ensure that stakeholders and advocates are able to sufficiently understand the impact of the new system on patient care.

The SNF PPS rule was [finalized](#) in August without major changes to the implementation of the PDPM.

3. Home Health Prospective Payment System

In August, the CPR Steering Committee submitted [comments](#) on the proposed FY 2021 Home Health PPS rule. The letter echoed many of the same concerns with the SNF PPS, as CMS implemented a similar new payment model (the Patient-Driven Groupings Model) for home health agencies (HHAs) beginning January 1, 2020. Many HHAs have carried out similar reductions in therapy staffing and CPR has received troubling reports of directives to decrease therapy minutes provided and/or reject certain patients due to their categorization under the new Home Health Resource Groups. As with the SNF PPS, CPR urged CMS to collect and report robust data on the implementation of the PDGM and its effects for patient access to home health care.

Additionally, the Home Health PPS proposed rule included one of the first regulatory proposals to make permanent some of the expanded telehealth flexibilities advanced during the COVID-19 public health emergency (PHE). CPR supported the proposal to increase home health patients' access to telehealth, but urged CMS to maintain access to in-person care for all patients when considering further regulatory action to expand telehealth under the Medicare program.

The Home Health PPS rule was [finalized](#) in November without major changes to the implementation of the PDGM. CMS did finalize the proposal to extend certain telehealth flexibilities in the home health setting.

4. Physician Fee Schedule Proposed Rule

In October, CPR submitted [comments](#) on the proposed 2021 Physician Fee Schedule (PFS), which sets forth payment rates for physicians and other providers for services in Medicare Part B. CPR's comments focused on the expansion of telehealth past the end of the COVID-19 PHE as well as proposed changes to reimbursement rates for certain services. 32 CPR member organizations signed on to this letter.

a. Expansion of Telehealth Under the PFS

In the PFS proposed rule, CMS proposed to significantly expand the provision of telehealth under the Medicare program, proposing to permanently add several services to the Medicare telehealth list and to create a new category of services temporarily authorized for telehealth. CMS did not propose

to authorize therapy services for permanent telehealth authorization, noting that the authority to allow therapists to furnish telehealth past the end of the PHE must be granted by Congress.

CPR supported the expansion of telehealth to ensure that patients are able to benefit from virtual care. However, CPR also cautioned CMS to ensure that beneficiaries, especially those in need of rehabilitation, are able to access the most appropriate care in the most appropriate settings, and to ensure that access to in-person services is not decreased due to the expansion of telehealth. CPR encouraged CMS to expand access to patient-centered telehealth in as many appropriate forms as possible, while ensuring that telehealth adds to existing forms of care without replacing or supplanting these modalities.

CMS finalized the addition of the majority of the proposed services to either the permanent or temporary (Category 3) telehealth list in the [final rule](#), released in December.

Earlier in October, CPR sent a [separate letter](#) to CMS urging temporary authorization for a list of speech language pathology and audiology codes to be furnished via telehealth for the duration of the PHE. 39 CPR member organizations signed on to this letter.

b. Impact of Proposed Changes to Evaluation and Management Visit Reimbursement

CMS also proposed to increase payment for in-office and outpatient evaluation and management (E/M) services in 2021. However, due to the statutory budget neutrality requirement imposed on the PFS, this change was set to result in an overall decrease to the conversion factor applied to all PFS services, resulting in significant decreases in overall reimbursement, especially for specialties such as therapy and physical medicine that treat a high number of rehabilitation patients.

CPR noted that providers of rehabilitation care are already facing serious financial strain due to the impacts of the COVID-19 pandemic, as well as the financial incentives placing downward pressure on access to rehabilitation therapies in the SNF and Home Health payment systems. CPR urged CMS to use all authorities to ensure that patient access to care is not adversely affected by the proposed reimbursement cuts and to protect the viability of rehabilitation physicians and therapists in 2021 and beyond.

CMS finalized the PFS rule without substantive changes to these provisions, noting that the agency had limited authority to address the budget neutrality requirement. However, in the omnibus legislation passed by Congress at the end of 2020 (the Consolidated Appropriations Act, 2021), the PFS cuts were mitigated by two statutory provisions. First, the PFS received a one-time, \$3 billion increase in payment to allow for all specialties to receive a 3.75 percent increase in reimbursement over the level laid out in the final rule. This increase will apply *only* for 2021. Second, CMS delayed the implementation of a new add-on code for complex patient E/M services for four years, which will further mitigate the regulatory cuts by approximately 3%.

5. Additional HHS Payment Regulations Impacting Rehabilitation

a. Notice of Benefit and Payment Parameters Proposed Rules

In March, CPR submitted [comments](#) on the proposed 2021 Notice of Benefit and Payment Parameters, the regulation setting forth policies for health insurance plans governed by the Affordable Care Act (ACA). These comments focused on key proposed policies that would impact enrollees in need of medical rehabilitation and post-acute care. 27 CPR member organizations signed on to this letter.

- Changes to the automatic enrollment process – the Department of Health and Human Services (HHS) proposed to end the automatic enrollment process for individuals who qualify for \$0 premium plans as a result of advance premium tax credits. CPR strongly opposed this proposal, which would lead to more individuals being uninsured by driving up premiums. In response to “overwhelming” opposition from stakeholders, HHS did not finalize any changes to the automatic re-enrollment process.
- Expanding special enrollment periods – HHS proposed to expand special enrollment periods for beneficiaries who become newly ineligible for cost-sharing reductions to change their qualified health plan levels. CPR supported this proposal, noting that the change would increase access to affordable, comprehensive health coverage. HHS finalized this proposal with some minor modifications.

Earlier than expected, the Trump Administration issued the 2022 proposed NBPP in December 2020. The CPR Steering Committee submitted [comments](#) on the proposed rule, focusing on several proposals:

- CPR opposed a proposal to provide states with increased flexibility to privatize the ACA enrollment process, which could cause confusion and potentially steer consumers towards short-term, limited duration health plans or other less comprehensive plans that may not meet their needs.
- CPR opposed the proposed decrease to the federal marketplace user fee, which supports functions including the operation of the HealthCare.gov website, the marketplace call center, the Navigator program, consumer outreach, and advertising.
- Finally, CPR opposed the codification of guidance weakening the requirement that state innovation waivers (Section 1332 waivers) must cover as least as many people, with coverage at least as comprehensible and affordable as without the waiver, while reducing costs.

The 2022 NBPP was [finalized](#) on January 15, a little more than a week after the close of the public comment period. The Administration finalized each of the proposals opposed in the Steering Committee’s letter without substantive changes. The Biden Administration has frozen the effective dates of all final rules not yet in effect on January 20; however, in most cases, the Administration will have to put forth a separate proposed rule via notice-and-comment rulemaking to rescind the final rule entirely or make substantive changes.

b. Medicare Advantage/Part D Proposed Rule

In April, CPR submitted [comments](#) on the proposed 2021/2022 Policy and Technical Changes proposed rule for the Medicare Advantage (MA) and Medicare Part D programs. 26 CPR member organizations signed on to this letter. CPR's comments focused on the following topics:

- Revisions to supplemental benefits for beneficiaries with chronic conditions (SSBCI)
- Ensuring network adequacy requirements for MA plans
- Star rating program enhancements to account for access to rehabilitation in inpatient and outpatient settings
- New tools for beneficiaries under Medicare Part D to better understand prescription drug costs.

The CPR comment letter also reiterated key points addressed in previous years' letters regarding access to care in IRFs under the MA program. The Trump Administration finalized part of the 2022 MA/Part D rule in October and issued another [final rule](#) on January 15. The latter finalized the proposed revisions to SSBCI, the network adequacy changes, and the real-time beneficiary reporting tool, but did not add new star rating program metrics regarding inpatient rehabilitation.

6. Addressing the Long-Term Impacts of COVID-19

As CPR continues to observe the impact of the COVID-19 pandemic, member organizations became increasingly concerned about the long-term impact of the virus on many patients, who face significant, lingering symptoms impacting their health and function and perhaps even long-term or permanent disability as a result of their COVID-19 infection. CPR feels that though there is growing media attention to these long-term cases, policymakers still do not fully understand the breadth of the impact of the virus past the acute stage of infection. Many types of rehabilitation may be necessary to address long-term COVID-19 symptoms, and the health care system may not be fully prepared to handle the influx of patients requiring long-term COVID-related care.

In early December, CPR circulated a call for feedback to both patients and providers seeking stories of the long-term impact of COVID-19 as well as policy recommendations to increase the availability of and access to long-term rehabilitation for COVID-19 patients. CPR expects that long-term COVID-19 rehabilitation will continue to be a high priority into 2021, and the Steering Committee is reviewing responses to our solicitation to develop a set of policy priorities for the Coalition as well as a stable of patient stories to ensure that policymakers are aware of the significance of this issue.

7. HHS Sunset Proposal for Existing Regulations

In December, CPR submitted [comments](#) in response to the Department of Health and Human Services' (HHS) proposed rule on Securing Updated and Necessary Statutory Evaluations Timely (SUNSET). 36 CPR member organizations signed on to this letter.

HHS proposed to set an automatic expiration date for nearly all regulations issued by the agency, save for a few categorical exceptions, unless agency staff performs an affirmative review and determines the regulation should stand. In the two years after finalization of the rule, HHS would be required to review all regulations older than ten years, and more recent regulations would expire at ten years from their effective date following that period if they are not reviewed and approved.

CPR strongly opposed this proposal on the grounds that the proposed process was overly broad, the requirements on agency staff would be onerous and impede important and timely regulatory work, and the blanket expiration of regulations could significantly erode the regulatory framework established over decades to protect patients. CPR also opposed the condensed (30-day) comment period as insufficient to appropriately assess and respond to such a significant proposal. However, CPR's comments reiterated that the coalition does not oppose more targeted modernization of specific HHS regulations that are outdated or inconsistent with patient-centered clinical practice.

The Trump Administration finalized this [proposal](#) on January 8 without major changes. Though HHS noted that "commenters generally opposed the proposed rule," the agency finalized the bulk of the proposal, while extending the period for reviewing rules that are already more than 10 years old from two to five years and allowing a one-time, one-year extension of the review period for an individual regulation at the Secretary's discretion. HHS also excluded most Food and Drug Administration (FDA) regulations as well as the annual NBPP from the review requirements.

As previously noted, the Biden Administration has frozen the implementation of this rule and CPR will keep members informed of any proposals to substantively revise or rescind this regulation.

8. Timeline for Implementation of the IMPACT Act of 2014

In July, CPR sent a [letter](#) to Congress and engaged with Congressional leaders urging a "reset" of the timeline for implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. This legislation requires CMS to put forth a proposed model for a unified post-acute care payment system, merging the payment systems for IRFs, SNFs, Home Health, and Long-Term Acute Care Hospitals (LTACHs) into one system. CPR noted that between the impact of COVID-19 and the payment reforms recently implemented in the various post-acute care payment systems, the original timeline of the IMPACT Act no longer reflects the needs of the Medicare program or its beneficiaries. CPR urged Congress to consider a legislative reset – or a complete rethinking of the concept of unified post-acute care payment – to allow for sufficient reevaluation of the current system and analysis of the data to respond to the pandemic. 23 CPR member organizations signed on to this letter.

In November, Rep. Terri Sewell (D-AL) introduced H.R. 8826, [The Resetting the IMPACT Act \(TRIA\) of 2020](#). This bill would reset and recalibrate the IMPACT Act in line with the goal of CPR's letter. Though the bill was not passed by the end of the year, CPR expects similar legislation to be introduced early in the 117th Congress and will keep members informed of any further developments regarding implementation of the IMPACT Act.

9. Medicare Competitive Bidding Program

In March, the CPR Steering Committee sent a joint letter with the Independence Through Enhancement of Medicare and Medicaid (ITEM) Steering Committee to [Congress](#) and [CMS](#) requesting that non-invasive ventilators (NIVs) be exempted from the January 2021 round of the Medicare Competitive Bidding Program (CBP). Given the impact of the COVID-19 specifically regarding respiratory distress, the coalitions believed it was critical to postpone application of competitive bidding to NIVs. Stakeholders have expressed long-standing concerns that the CBP has the potential to limit access, choice, and quality of care for impacted items. In April, CMS [announced](#) that it was removing the NIV product category from Round 2021 entirely, marking a significant victory for our efforts on this issue.

10. Extension of COVID-19 Regulatory Flexibilities

In December, the CPR Steering Committee sent a [letter](#) to HHS in response to the Department's Request for Information on "Regulatory Relief to Support Economic Recovery." HHS specifically sought stakeholder feedback on whether and how to extend or make permanent a number of regulatory flexibilities taken during the COVID-19 PHE. CPR provided several recommendations for policies to increase access to rehabilitation care after the PHE is lifted:

- CPR urged CMS to maintain the waiver of the "**three-hour rule**" for IRF patients for at least six months after the expiration of the PHE, and to consider modifications to the interpretation of the rule after the pandemic to clarify that it should not be used as a determinative rule and to provide flexibility to count additional skilled services towards satisfaction of a patient's three hours of intensive rehabilitation therapy.
- CPR urged CMS to extend the waiver of the "**60 percent rule**" for IRFs for at least six months after the PHE, and to consider further reforms to ensure that patients, especially those suffering long-term symptoms as a result of COVID-19, are able to receive the most appropriate care in the most appropriate setting for their needs.
- CPR also reiterated our previous comments regarding the expansion of **telehealth** services and authorities in Medicare, urging CMS to advance patient-centered policy to make telehealth widely available while maintaining access to in-person care.
- CPR urged CMS to extend the waiver of the "**three-day prior hospitalization requirement**" for patients to qualify for SNF admission for at least six months after the PHE, and to permanently modify the interpretation of this requirement to allow observation days to count towards satisfaction of the rule.

11. New Coalition Members

CPR also added three new members in 2020: the American Network for Community Options and Resources (ANCOR), the Association of Assistive Technology Act Programs (ATAP), and the Spina Bifida Association. This brings the total number of CPR members to 53 organizations. We look forward to continuing to expand in 2021 and furthering our goal of increasing access to rehabilitation care for people with disabilities, injuries, illnesses, and chronic conditions.

We invite all CPR members to join us (virtually) for our 2021 Annual Meeting, where we will discuss our 2020 accomplishments and our policy priorities for the coming year. The 2021 CPR Annual Meeting will be held on **Tuesday, January 26 from 12:30-2pm ET**. All current members should have received a calendar invite with the dial-in information. If you have any questions regarding the Annual Meeting, please contact Joe Nahra at Joseph.Nahra@PowersLaw.com or Emily Goodwin at Emily.Goodwin@PowersLaw.com.