



June 7, 2021

SUBMITTED ELECTRONICALLY VIA [www.regulations.gov](http://www.regulations.gov)

Ms. Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022 (CMS-1746-P)**

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Fiscal Year (FY) 2022 Skilled Nursing Facility Prospective Payment System (SNF PPS) proposed rule. This letter focuses on the Centers for Medicare and Medicaid Services' (CMS) implementation of the Patient-Driven Payment Model (PDPM) and its impact on access to therapy in Skilled Nursing Facilities (SNFs).

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the clinicians who serve them – who are frequently in need of the rehabilitation care provided in SNFs and other settings of post-acute care (PAC).

### **Overview**

The proposed rule includes technical and payment policy updates to the SNF Prospective Payment System (PPS) and administrative changes to the SNF Quality Reporting Program (QRP) and Value-Based Purchasing Program (VBP). We do not offer comment on these proposed policies at this time.

The rule also provides new details on the implementation of the Patient-Driven Payment Model (PDPM) in the SNF PPS, which came into effect on October 1, 2019. The rule states that while the PDPM was intended to be implemented in a budget-neutral manner, the parity adjustment in the FY 2020 final rule “may have inadvertently triggered a significant increase in overall payment levels under the SNF PPS.” At the same time, CMS notes that there has been a significant negative impact in the amount of therapy provided to SNF patients under the PDPM,

at least some of which can be attributed solely to the new payment model and not to effects of the COVID-19 public health emergency (PHE). Therefore, we offer comments on the impact of PDPM on patient access to care in the SNF PPS and recommendations to ensure that the PDPM does not provide further barriers to accessing care for individuals in need of skilled nursing services.

### **Reported Impact of the Patient-Driven Payment Model**

Though the PDPM was implemented in October 2019, prior to the issuance of the FY 2022 proposed rule, CMS has not provided data on the rollout of this new model and its impact on patients' ability to access therapy in the SNF setting. The Coalition to Preserve Rehabilitation and other stakeholders representing individuals who receive care in SNFs have long raised concerns about the model's effects "on the ground" in SNFs after the implementation of the PDPM. Based on reports from organizations representing patients and therapists, it seems as if the model almost immediately resulted in impeded access to therapy for patients who need skilled care, despite CMS' statements that the PDPM (along with the Patient-Driven Groupings Model implemented in the Home Health PPS) is not intended to impact Medicare coverage of SNF and/or home health services.

In this year's proposed rule, CMS for the first time provides details on the actual impact of PDPM for access to therapy, and the information is concerning, to say the least. For example, CMS states that "[b]eginning almost immediately with PDPM implementation (and well before the onset of the pandemic), the average number of therapy minutes SNF patients received per day dropped to approximately 62, a decrease of over 30 percent." Further, CMS acknowledges that "it is clear" that the overall decrease in therapy provided to SNF patients is due to the PDPM and not other factors. The rule also references media reports of "significant" changes in therapy staffing and care directives at the outset of PDPM, aligning with concerns that CPR and other stakeholders have raised since the proposal of the new model.

Additionally, CMS states that there has been a major increase in the use of group or concurrent therapy relative to individualized therapy since PDPM began, from 1% of stays including each therapy to 29% and 32%, respectively. The rule clearly indicates that these effects are a direct result of the PDPM and not other factors, including the COVID-19 PHE. Despite the significant decrease in therapy provided to SNF patients, CMS professes that there were "no significant changes in health outcomes for SNF patients." This defies logic when one considers decades of research on the link between rehabilitation therapy and improved functional outcomes. If no significant changes in outcomes have been detected under the SNF PPS thus far, we strongly question whether this is sustainable. Less access to rehabilitation therapy in any setting is contrary to the interests of Medicare beneficiaries, and it is critical to ensure that payment schema do not constrain the provision of care to individuals who need these services.

### **Proposed Rule Supports Observations from the Field**

This new data from CMS supports the reports from rehabilitation patient and provider stakeholders about troubling indicators in SNFs soon after the implementation of PDPM. Anecdotal evidence suggested that patients in need of skilled care began to face obstructed

access to therapy as soon as the model came into effect. CMS reiterates in the proposed rule that “financial motives should not override the clinical judgment” of a provider or pressure therapists into providing less than appropriate therapy. It is clear, however, that PDPM has, in fact, driven SNFs to change the way they offer therapy, and patients are facing the consequences of reduced access to these critical services.

### *Group Therapy Under PDPM*

The PDPM includes a cap on the provision of group and concurrent therapy, limiting these therapies to 25% of an individual patient’s therapy time by discipline. However, the PDPM does not include any penalty for exceeding this limit, and it is our understanding that there has been little, if any, enforcement by CMS of the 25% cap. Stakeholders, including the Coalition to Preserve Rehabilitation aired concerns about the incentive to reduce individualized therapy when the PDPM was proposed, and initial reports from therapists since the model’s implementation have suggested these concerns were warranted. For example, a survey conducted by the American Physical Therapy Association found that more than three quarters of SNF-based respondents reported an increase in the use of group therapy over the past year, and more than 40% reported that their employer mandated these changes. Similar results were reported for concurrent therapy utilization in SNFs as well. The American Speech-Language-Hearing Association also conducted a survey and found 38% of its members reported changes in their employment status ranging from layoffs or a reduction in hours and salaries. Many reported pressure to provide group and concurrent therapy as well. While group and concurrent therapy can be valuable and appropriate in certain circumstances, we believe individualized therapy should not be deemphasized based on payment system incentives. However, this has clearly been the case so far since PDPM was implemented, and we urge CMS to address these incentives.

### *Decreasing Therapy Staff*

One area that is not specifically addressed in CMS’ reported data, but that impacts patients’ access to care significantly, is the availability of skilled therapy staff in SNFs. As reported by all of the major rehabilitation therapy associations, soon after the implementation of the PDPM, SNFs across the country began to eliminate positions and drastically reduce hours for employed therapists due to the payment changes inherent in the PDPM payment model. Organizations representing therapists have also received reports from their members that remaining therapists had been directed to cycle patients more quickly through their therapy programs and decrease the therapy minutes provided, clearly in line with the data presented in the proposed rule. These reports are troubling and may indicate that the new SNF payment model is driving decisions based on financial considerations, rather than patient care needs. CPR continues to be particularly concerned about the provision of maintenance therapy, which is covered by Medicare as affirmed under the *Jimmo v. Sebelius* class action settlement but is often at risk of being cut or eliminated entirely. “Maintenance” therapy assists a patient to maintain or prevent deterioration of their functional status, as opposed to improving their functional abilities.

## **More Data is Needed to Understand PDPM's Impact on Patients**

Though CMS has now provided some indication of real-world data bolstering our previously expressed concerns, patients and organizations representing consumers are still largely reliant on anecdotal data and reports regarding barriers to access under the PDPM. In order to truly assess and understand the impact of this model on patients, robust data from CMS is critical. **We urge the agency to work to collect and publish data on therapy utilization, characteristics of patients receiving therapy, more granular patient outcomes data, and other information on the PDPM implementation in a timely fashion.** We strongly believe that the agency should report a broader range of data to ensure that stakeholders and patient advocates are sufficiently able to understand the barriers to accessing rehabilitation therapy inherent in this new system, and take immediate action to address these restrictions to better serve the rehabilitation needs of Medicare beneficiaries in the SNF setting.

Additionally, we urge CMS to report this data at least quarterly, rather than annually, to ensure that patients who may face decreased access to therapy do not have to wait a full year or more to address these issues. Transparent and detailed data reporting will allow stakeholders in the rehabilitation and patient advocacy community to work with CMS to develop improvements to the system to properly serve beneficiaries and allow the reimbursement system to provide the skilled rehabilitative care they need.

\*\*\*\*\*

We greatly appreciate your consideration of our comments on the FY 2022 SNF PPS proposed rule. Should you have any further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for CPR, by e-mailing [Peter.Thomas@PowersLaw.com](mailto:Peter.Thomas@PowersLaw.com) or [Joseph.Nahra@PowersLaw.com](mailto:Joseph.Nahra@PowersLaw.com), or by calling 202-466-6550.

Sincerely,

## **The Undersigned Members of the Coalition to Preserve Rehabilitation**

ACCSES

American Academy of Physical Medicine & Rehabilitation

American Association of People with Disabilities

American Association on Health and Disability

American Music Therapy Association

American Occupational Therapy Association

American Physical Therapy Association

American Speech-Language-Hearing Association

American Spinal Injury Association

American Therapeutic Recreation Association

Association of Rehabilitation Nurses

Association of University Centers on Disabilities

*Brain Injury Association of America\**

*Center for Medicare Advocacy\**

***Christopher & Dana Reeve Foundation\****

Clinician Task Force

Disability Rights Education and Defense Fund

***Falling Forward Foundation\****

Lakeshore Foundation

National Association for the Advancement of Orthotics & Prosthetics

National Association of Social Workers (NASW)

National Association of State Head Injury Administrators

***National Multiple Sclerosis Society\****

Rehabilitation Engineering and Assistive Technology Society of North America

United Cerebral Palsy

***United Spinal Association\****

***\* CPR Steering Committee Member***