July 16, 2021

Benjamin C. Silver, Ph.D.
Project Director, Unified PAC PPS Prototype
RTI International

Allison Dorneo
Economist
RTI International

Re: RTI/CMS Technical Expert Panel on Unified Post-Acute Care Payment – Response to June 2021 TEP Meeting

Dear Dr. Silver and Ms. Dorneo:

On behalf of the Coalition to Preserve Rehabilitation (CPR), we thank you for the opportunity to participate in the June 2021 Technical Expert Panel (TEP) on the development of a unified post-acute care prospective payment system (unified PAC PPS) as an observer and to offer feedback on RTI International's work thus far. We appreciate the significant expertise that has gone into development of the unified PAC PPS over the past several years and thank you and your team for your continued engagement and consideration of a wide range of stakeholder voices through the TEP. However, we would like to take this opportunity to address our concerns with the underlying premise of a unified post-acute care payment system and its potential impact on patients with complex disabilities, injuries, and/or chronic conditions.

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 post-acute care settings, including inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), long-term acute care hospitals (LTCHs), and home health agencies (HHAs). These PAC providers serve a vital role in improving health and functional status, preventing deterioration of function, and enhancing quality of life for seniors and individuals with disabilities on Medicare and all payers.

Overview

As a coalition, CPR's primary focus is ensuring that all patients, especially those with significant and complex needs such as brain injury, stroke, multiple sclerosis, spinal cord injury, amputation, and other serious disabilities and chronic conditions are able to access the medically

necessary care they need, in the most appropriate setting, in order to maintain and improve their health and function. Unfortunately, many patients face severe barriers to access for post-acute care, whether due to restrictive coverage regulations, perverse payment incentives, or other burdens. CPR has long held significant concerns that a unified PAC prospective payment system may further compromise access to rehabilitation care for Medicare beneficiaries in need of these services, likely impacting the highest-need patients most severely.

We also have stated our concerns with the timeline for preparing and delivering the unified PAC PPS prototype, particularly in light of both the dramatic impact of COVID-19 on the PAC ecosystem writ large and the significant changes recently implemented in individual PAC payment systems (i.e., the SNF and HHA prospective payment systems). We urge RTI and the Centers for Medicare and Medicaid Services (CMS) to seriously consider these concerns and ensure that the most vulnerable patients are not harmed by any unified PAC PPS proposal.

Timeline for Prototype Delivery

Notwithstanding our hesitancy regarding the viability of a unified PAC PPS, we have significant concerns about the current timeline for the development and release of the RTI/CMS prototype. Simply put, the underlying data that is being used to develop the prototype in its current form is no longer reflective of the current state of the post-acute care system. Utilizing this data is likely to result in an inappropriate snapshot of Medicare's continuum of post-acute care services and could lead to significant problems with the model, potentially leading to inequities and barriers to patient access that will be "locked-in" to the Medicare PAC payment system for years to come.

The IMPACT Act, of course, could not anticipate and did not consider the widespread effects of the COVID-19 pandemic. PAC providers are dealing with the same public health crisis as the rest of the health care system and are likely to continue to see their operations significantly impacted by COVID-19 for years to come. Even when the public health emergency is lifted and the threat of infection continues to lessen due to widespread vaccinations, many patients will face complex and ongoing rehabilitation needs as a result of the virus (including the so-called "Long COVID" symptoms that are expected to impact as many as 30% of those infected with SARS-CoV-2), which will require multidisciplinary, coordinated treatment in a variety of PAC settings.

Furthermore, in recent years and since the gathering of the initial data being used in RTI's work, several of the individual PAC payment systems have undergone significant changes that have seriously impacted the provision of care. In particular, the Patient-Driven Payment Model (PDPM) in the SNF PPS and the Patient-Driven Groupings Model (PDGM) in the Home Health PPS have had immediate effects on the availability of services in these systems, the types of services available, and the barriers to access levied on beneficiaries. CMS has recently acknowledged the severity of these effects, which had been reported by patients, providers, and advocates almost immediately upon the implementation of these new models, in recent proposed

rulemaking. For example, CMS stated in the FY 2022 SNF PPS proposed rule[1] that "beginning 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." Similarly, there has been a dramatic increase in the use of group or concurrent therapy relative to individualized therapy since PDPM began, and similar effects have been reported in the Home Health PPS. These changes are troubling in and of themselves, but we are particularly concerned that they will further distort the prototype for the proposed unified PAC PPS model.

Attempting to implement a wholly new payment system that unifies diverse settings of care without evaluating the rapidly changing needs of PAC beneficiaries and providers as a result of the pandemic and payment system changes could undermine the existing PAC system. Most importantly, advancing a prototype based on outdated and inconsistent data will likely negatively impact beneficiaries' ability to access the care they need in the most appropriate setting for their condition. We recognize that the IMPACT Act mandates certain timelines for developing the unified PAC PPS prototype and that RTI is bound by the strictures of the law and its engagement with CMS.

However, we urge you to seriously consider the shortcomings of the current data set and emphasize these issues clearly in any eventual presentation of the model. Additionally, we continue to support and closely monitor the progress of legislation currently being considered in Congress, *The Resetting the IMPACT Act (TRIA) of 2021*, that would extend the IMPACT Act's implementation timeline to allow for these shortcomings in the data to be corrected.

Unifying Disparate Settings and Patient Populations

As previously stated, CPR members have long held concerns about whether a unified PAC PPS can appropriately combine and still differentiate between the widely disparate patient populations and highly distinct settings that currently make up the post-acute care system. While there may be some proportion of patients that could be appropriately served in more than one setting (so-called "borderline" cases), most PAC patients are directed to the setting of care that is most able to properly treat their individual condition. These are clinical decisions made by physicians with experience in rehabilitation and post-acute care. Assigning a patient who needs the intensive, inpatient, multidisciplinary care offered in an inpatient rehabilitation hospital to a skilled nursing facility, for example, could result in significant deleterious effects on the individual's health, function, and capacity for improvement following a serious injury, complex disability, or chronic condition.

Attempting to uniformly lump all PAC patients into one bucket for purposes of payment will almost certainly impact those patients with extensive needs. One unified payment system for all post-acute care will likely overcompensate providers who treat patients with relatively low intensity rehabilitation needs while undercompensating providers who treat patients requiring

[1] 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, 86 Fed. Reg. 19,954 (Apr 15, 2021).

higher-intensity medical and rehabilitation services. More troubling is the prospect of a severely compromised patient (such as an individual with a traumatic brain injury and resulting functional impairment or an individual with quadriplegia stemming from a major trauma) being denied the full extent of the medical and rehabilitation care to which they are entitled under Medicare due to a relative lack of resources available under a unified PAC payment system.

The populations that are treated in the four existing PAC settings (often derogatorily referred to as PAC "silos") are not interchangeable. In fact, in many instances, it is a misnomer to even refer to home health benefits as post-acute, as some patients receive home health care without a previous acute hospital stay. Coverage of home health services is not limited to beneficiaries with a prior hospitalization, and strictly confining this population within a unified PAC system has the potential to distort the care they receive, and the amount the provider is paid for these services. Attempting to create a streamlined payment system for post-acute care could potentially erase the existing and necessary differences in the treatment provided to these differing patient populations. Having witnessed the deliberations of the most recent TEP, our concerns are heightened, not allayed, with the whole concept of a unified PAC payment system for Medicare beneficiaries.

Ensuring Access to Care for High-Needs Patients

Regardless of the overall merits of pursuing a unified PAC PPS, it is critical that the primary goal of any new payment system be ensuring that patients are able to access the care they need without undue burdens or barriers. This is particularly important for individuals with complex conditions or serious injuries or illnesses. We have significant concerns that the model in its current form, as presented during the June 2021 meeting of the TEP, would not meaningfully accomplish this goal. The movement towards a unified payment system has the potential to underserve beneficiaries with some of the most serious and complex injuries, disabilities, and chronic conditions. In particular, we are concerned about the continued availability and provision of "maintenance" therapy, which assists a patient to maintain or prevent deterioration of their functional status, as opposed to improving their functional abilities. Maintenance therapy is covered by Medicare as affirmed under the *Jimmo v. Sebelius* class action settlement, but is often at risk of being disincentivized, cut, or eliminated entirely.

This issue is clearly highlighted by the current treatment and consideration of cognitive function in the proposed model. According to RTI, the data as currently analyzed does not identify cognitive function as a "case-mix adjuster" under the prototype, and in fact, RTI states that cognitively impaired patients are currently labeled as having lower costs than non-cognitively impaired individuals. This is alarming, to say the least, and does not comport with simple logic or provider experience of treating patients with cognitive impairments in PAC settings.

There are numerous potential explanations for the inconsistencies in the model's treatment of cognitive function. For instance, it may be that the provision of key services to cognitive patients (such as additional nursing, social work, family education and training, etc.) are not necessarily reflected in the existing payment systems that tend to collect data on physical and occupational therapy, for instance. Our concern is that this issue illustrates the inherent health

care inequity that is engrained in the current PAC system, where individuals with cognitive impairments are systematically underserved. Design of a prospective payment system for all of post-acute care that builds these inequities into a new payment system will perpetuate and potentially exacerbate these inequities for years to come.

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We greatly appreciate your consideration of our feedback on the development of the unified PAC PPS prototype. We look forward to remaining engaged with this process to ensure that any model adequately addresses the needs of individuals with complex disabilities and conditions requiring intensive treatment in PAC settings. Should you have any further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for CPR, by e-mail at Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ALS Association
American Academy of Physical Medicine & Rehabilitation
American Congress of Rehabilitation Medicine
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
Amputee Coalition
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