June 18, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1718-P
P.O. Box 8016
Baltimore, MD 21244-8016

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 2020

Submitted electronically to: http://www.regulations.gov.

Dear Administrator Verma:

The undersigned organizations appreciate the Centers for Medicare & Medicaid Services' (CMS) ongoing focus on resident care in skilled nursing facilities (SNFs). However, we believe that the proposed rule weakens every Medicare-covered resident's access to quality care, as required under the federal Nursing Home Reform Law.[1] Specifically, our organizations are concerned that allowing more residents to participate in group therapy, along with the increased financial incentives to do so and inadequate enforcement of the group and concurrent therapy limits announced last year, may result in some nursing homes forgoing individual therapy whenever possible.

Background

In final rules published in August 2018,[2] CMS finalized changes to define group therapy "as the practice of one therapist or therapy assistant treating four patients at the same time while the patients are performing either the same or similar activities."[3] As CMS explained the reasoning for limiting group therapy to four residents, "large groups, such as those of five or more participants, can make it difficult for the participants to engage with one another over the course of the session."[4] CMS also previously finalized changes to allocate costs among all residents participating in group therapy.[5] As CMS noted, "when a therapist treats four patients in a group for an hour, it does not cost the SNF four times the amount (or four hours of a therapist's salary)

[1] 42 U.S.C. § 1395i–3.
[2] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, 83 Fed. Reg. 39162, 39183-39265 (Aug. 8, 2018). Available at https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf.
[3] 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 2020, 84 Fed. Reg. 17620, 17633 (Apr. 25, 2019) (citing 83 Fed. Reg. 39162, 39183-39265). Available at https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08108.pdf.
[4] *Id.* at 17634.
[5] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012, 76 Fed. Reg. 48486, 48511 (Aug. 8, 2011). Available at https://www.govinfo.gov/content/pkg/FR-2011-08-08/pdf/2011-19544.pdf.

to provide those services."[6] This change was in response to concerns that the previous method for reporting group therapy, which allowed SNFs to bill one hundred percent of a therapist's time for each resident in the group, created "an inappropriate payment incentive to perform the group therapy in place of individual therapy . . . ."[7]

On April 25, 2019, CMS issued a notice of proposed rulemaking that would, among other changes, revise the definition of group therapy to allow up to six residents to participate in a group therapy session.[8] CMS stated that, based on its review of inpatient rehabilitation facility (IRF) and outpatient therapy settings, therapists seem to be capable of managing various group sizes.[9] The revision to the definition of group therapy would take effect after the implementation of the new Patient Driven Payment Model (PDPM), which will no longer factor allocated therapy minutes in determining reimbursement rates.[10]

Comments

Regulations already place residents at risk of not receiving individual therapy based on financial considerations. Federal regulations limit group and concurrent therapy to a combined 25 percent of each resident's total therapy regimen, by discipline, during his or her Medicare-covered stay.[11] As CMS made clear in previous rulemaking, group and concurrent therapy are not appropriate for all residents or for all conditions.[12] These forms of therapy are meant to be a supplement to individual therapy and not a substitute.[13] Importantly, CMS noted that "individual therapy is generally the best way of providing therapy to a resident because it is most tailored to that specific resident's care needs."[14]

Despite recognizing individual therapy as the preferred method for resident care, CMS announced last year that it would make little effort to enforce the 25 percent limit on non-individual therapy. According to CMS, "when the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline . . . providers would receive a non-fatal warning . . . ."[15] More simply stated, "[t]here will be no penalty for exceeding the 25% combined

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[6] *Id.* at 48512.
[7] *Id.* at 48511.
[8] 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 2020, 84 Fed. Reg. at 17633.
[9] *Id.* at 17634.
[10] *Id.* at 17624
[11] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, 83 Fed. Reg. 39162, 39238 (Aug. 8, 2018). Available at https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf.
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *See id.* at 39243 ("[W]e are finalizing our proposal . . . to implement a non-fatal warning edit on the validation report upon submission when the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline, which would alert the provider to the fact that the therapy provided to that resident exceeded the threshold.").

concurrent and group therapy limit."[16] The lack of a penalty for exceeding the group therapy limit is highly problematic given CMS's recognition that SNFs "may base decisions regarding the particular mode of therapy to use for a given resident on financial considerations rather than on the clinical needs of SNF residents."[17] As CMS knows, one of the biggest financial considerations is that group or concurrent therapy is considerably less costly for SNFs because it allows a single therapist to work with multiple residents at the same time.

Revising the definition of group therapy now to allow therapists to work with even more residents at the same time creates a bigger financial incentive for SNFs once PDPM is in effect. Under PDPM, a SNF's per diem reimbursement for each resident will be based on five case-mix adjusted components, including physical therapy, occupational therapy, and speech language pathology. Medicare reimbursement for group therapy will no longer be based on each resident's allocated therapy minutes but rather will depend on the resident's characteristics. Discussing this change last year, CMS noted that it was concerned "SNFs may once again become incentivized to emphasize group and concurrent therapy, over the kind of individualized therapy which is tailored to address each beneficiary's specific care needs which we believe is generally the most appropriate mode of therapy for SNF residents."[18] CMS's solution to this problem was the "non-fatal warning" described above.[19] CMS has proposed nothing in this year's NPRM to strengthen its "non-fatal warning" to facilities, while increasing even further the financial incentives to place residents in larger groups for therapy.

While CMS acknowledged concerns that PDPM may incentivize nursing homes to favor group and concurrent therapy over individual therapy, CMS's solution was not a real deterrent. Under the previous payment model (RUG-IV), an excess in group therapy meant, "the minutes of therapy received in excess are not counted towards the calculation of the RUG–IV therapy classification."[20] As a result, nursing homes did not have a financial incentive for exceeding the group therapy limit. Without similar enforcement of the non-individual therapy limit under PDPM, the proposed changes provide nursing homes with incentives to place additional residents in group therapy and pocket even more savings without penalty.

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[16] *See Fact Sheet: Concurrent and Group Therapy Limit*, CMS, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_Template_CGLimit_Final.pdf (last visited Apr. 24, 2019) (noting that "CMS will also monitor therapy provision under PDPM to identify facilities that exceed the limit, in order to determine if additional administrative or policy action would be necessary").

[17] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, 83 Fed. Reg. at 39238.

[18] *Id.*

[19] *See Id.* at 39238 ("We explained that because the proposed PDPM would not use the minutes of therapy provided to a resident to classify the resident for payment purposes, we would need to determine a way under the proposed PDPM to address situations in which facilities exceed the combined 25 percent group and concurrent therapy limit.").

[20] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, 83 Fed. Reg. at 39239.

Even if SNFs did not have a financial incentive to offer group therapy over individual therapy, CMS's basis for redefining group therapy is misguided. CMS bases its decision to revise the definition of group therapy, in part, on how group therapy is defined in IRF and outpatient therapy settings.[21] CMS explains that those settings have less restrictive definitions of group therapy and "therapists do seem capable of managing groups of various sizes."[22] CMS clarifies that "given the greater degree of similarity between the IRF and SNF settings in terms of the intensity of therapy and patient acuity, we believe that the IRF . . . definition would be more appropriate in the SNF setting."[23] However, CMS's reasoning is misguided.

SNFs and IRFs provide different levels of care. Chapter 1 of the Medicare Benefit Policy Manual (MBPM) states that IRFs are "designed to provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who . . . require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care."[24] Medicare coverage of IRF care depends, partly, on a patient's need for "ongoing therapeutic intervention of multiple therapy disciplines" for at least three hours a day, five days a week.[25] Additionally, while an IRF patient does not need to reach a prior level of functioning or complete independent in self-care, a degree of improvement is required.[26]

Conversely, Chapter 8 of the Medicare Benefit Policy Manual clearly states, because of the settlement agreement in *Jimmo v. Sebelius*,[27] that there is no improvement standard for Medicare coverage of SNF care.[28] SNF residents can continue receiving skilled therapy to maintain their condition or to slow or prevent further decline. Furthermore, SNF residents only need to receive daily skilled therapy in one discipline rather than multiple therapy disciplines as is required in IRFs.[29] CMS's claim that IRF and SNF settings are similar in terms of therapeutic intensity is wrong. IRFs by definition require a greater level of intensity. Given that IRFs provide more intensive therapy, it is not surprising that reports indicate IRF patients also have lower acuity than SNF residents.[30]

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[21] 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 2020, 84 Fed. Reg. at 17634.
[22] *Id.*
[23] *Id.*
[24] *Inpatient Hospital Services Covered Under Part A*, MBPM, CMS, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf (last visited Apr. 25, 2019).
[25] *See id.* (stating that, in some cases, patients are allowed to receive "at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period").
[26] Coverage of Extended Care (SNF) Services Under Hospital Insurance, MBPM, CMS, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf (last visited Apr. 25, 2019).
[27] No. 5:11-cv-17 (D. VT 2013).
[28] Coverage of Extended Care (SNF) Services Under Hospital Insurance, MBPM, CMS.
[29] Coverage of Extended Care (SNF) Services Under Hospital Insurance, MBPM, CMS.
[30] *See, e.g.*, Ying Zian et al., *Unexplained Variation for Hospitals' Use of Inpatient Rehabilitation and Skilled Nursing Facilities After an Acute Ischemic Stroke*, 84 Stroke 2836, (finding that "patients were less likely to receive care at an IRF if they were older, women, had a longer length of stay at the index hospitalization, or had comorbidities, such as prior stroke or transient ischemic attack, dementia and delirium, and hospitalization or SNF use, before the index stroke").

Conclusion

Our organizations respectfully ask CMS to meaningful enforce the group and concurrent therapy limits and to not revise the definition of group therapy. Under current regulations and upcoming policy changes, SNFs already have too many incentives to forgo individual therapy in favor of group therapy when possible. Moreover, CMS must not base its decision to redefine group therapy on how group therapy is defined in other settings that have different coverage criteria and patient acuity levels.

Sincerely,

American Academy of Physical Medicine & Rehabilitation
American Congress of Rehabilitation Medicine
American Spinal Injury Association
California Advocates for Nursing Home Reform
Center for Elder Law & Justice
Center for Medicare Advocacy
Falling Forward Foundation
Justice in Aging
Long Term Care Community Coalition
Massachusetts Advocates for Nursing Home Reform
Our Mother's Voice
Senior Citizens Law Office
National Association of Social Workers
The National Consumer Voice for Quality Long-Term Care