June 5, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1779-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

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 2024 (CMS-1779-P)

Dear Administrator Brooks-LaSure:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapy, occupational therapy and speech language pathology practitioners through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities, assisted living facilities, hospital outpatient, hospital inpatient, in the beneficiary's home, and in retirement communities. As a member-driven organization, NARA promotes the growth and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment and quality programs for skilled nursing facilities. Below are our comments related to the above proposed rule:

Proposed Updates to the SNF Payment Rates
NARA appreciates the net increase of 3.7%; while the increase is greatly appreciated, it does not cover the actual increase in costs for nursing facility operators. We urge CMS to utilize the most current economic data when issuing the Final Rule to account for current cost increases severely felt by long-term care providers. Nursing facility providers continue to struggle with inflation and staffing shortages while caring for patients requiring a much higher level of care.

Proposed Changes in PDPM ICD-10 Code Mapping
We do not support changing the category for unspecified substance use disorder codes from Medical Management to Return to Provider. These codes need to stay at Medical Management because providers are seeing an increase of these being underlying reasons why patients seek care. These were just flipped into this category for FY 2023. With CMS' focus on mental health

and health equity, providers are trying to treat patients with these underlying issues. We acknowledge as providers there are more appropriate codes that can be used to indicate whether the patient has substance abuse or dependence; however, the diagnosis codes come from the referring physician. Query rules make it complex for the nursing facilities to recommend the more specific codes to the physician. The time it would take to query with the physician on these codes creates an administrative burden to providers when it is the responsibility of the referring physician to code at the highest level of specificity. NARA recommends CMS continue to target physicians to aid in the transition of care via methods like the MLN909340 from March 2022.

NARA supports CMS' proposal to update any non-substantive changes to ICD-10 code mappings and lists used under PDPM through a subregulatory process that would consist of posting updated code mappings and lists on the CMS PDPM website, while requiring substantive revisions to be proposed and finalized through notice and comment rulemaking. We encourage CMS to post timely updates on its PDPM web site in a manner that is easy to find. Further, the updates should clearly identify the changes with specific effective dates that are reasonable for SNF staff to implement. All members of the interdisciplinary team, including therapy practitioners, should have access to education and resources to understand the implications of coding on patient categories and payment.

Changes to the Skilled Nursing Facility Quality Reporting Program

NARA recommends that CMS focus on developing quality measures that provide meaningful information to patients, caregivers, discharge planners, providers, and payers and adequately distinguish SNFs from one another without creating excessive administrative burden. This should include measures that reflect the contributions of physical therapy, occupational therapy, and speech language pathology practitioners particularly on patients' abilities to participate in rehabilitation therapy and achieve therapy goals. While we appreciate the removal of the bias that can exist, the Self-Care and Mobility measures should not be combined; they are separate and distinct functions. These measures separately are too critical to leave out of a post-acute care (PAC) function measure, especially in certain settings. We understand the reasoning for combining them, but this does not decrease the administrative burden on providers, and we believe they should remain separate to better understand the optimal interventions and outcomes for patients in each unique PAC setting.

The IMPACT Act requires CMS to retain at least one cross-setting function measure in the Post-Acute Care Quality Reporting Program (PAC QRP) that uses items within Section GG of the assessment instruments. The Section GG items assess a patient's capacity to perform daily activities related to self-care and mobility at admission and discharge. A measure development contractor for this measure convened a Technical Expert Panel in 2021 to obtain expert input on the development of a functional outcome measure for post-acute care (IRF, SNF, LTCH, HH). TEP members discussed the possibility of creating one measure to capture both self-care and mobility.

The American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA) released the TOPS study last year[1], where data from 1.4 million Medicare beneficiaries in SNFs, IRFs, and home health settings was analyzed. Medicare administrative claims and functional assessment data were studied to measure therapy utilization and the reported need for assistance with core activities of daily living, including self-care and mobility, at the start and end of a post-acute care stay. The study included looking at the relationship between intensity of occupational therapy and physical therapy services to change in patient functional status during their first PAC episode. 'Functional status' includes the patient's ability to perform dressing, bathing, toileting, feeding, walking/locomotion, and transferring. According to the findings, the intensity of therapy is associated with improved ability to perform everyday these functional activities as well as better functional outcomes and reduced risk of rehospitalization. Receiving high or typical intensity therapy was associated with more functional improvement than low intensity across all diagnoses. These findings were consistent for different types of conditions including joint replacement, stroke, and congestive heart failure suggesting a robust relationship between therapy intensity and meaningful outcomes.

Further, the TOPS study suggests that therapy is well targeted to the differing clinical needs and treatment goals of the populations served within each PAC setting as patients move through the recovery process. Although the PAC settings studied may have some overlap of patients, each setting serves a generally different patient population, in terms of their acuity and their treatment goals. We urge CMS to review the TOPS Study materials because it has important implications for SNF and PAC policies, as well as implications for CMS/RTI's current development of a prototype for a PAC unified payment model.

NARA agrees with TEP members' perspective that the salience of functional items is setting-specific and patient-dependent, and we support the examples given in Section 3.2.2 on page 17 of the PAC Function TEP Summary Report.[2] Given the TEP members' perspective and the TOPS study finding that each PAC setting serves generally different patient populations with varying clinical needs and treatment goals, NARA recommends CMS separate quality measures for self-care and mobility in order to ensure each setting is able to capture the items most relevant to its patient population needs and goals and use the measures to determine *meaningful* quality improvement activities. However, if CMS must use one measure, then NARA supports a composite functional outcome measure to ensure that it captures both self-care and mobility items rather than solely mobility items. Such a measure should include appropriate risk adjustment to account for differences in risk factors to enable more accurate comparisons of

[1] "Occupational Therapy and Physical Therapy Provide Significant Rehabilitative Value in Post-acute Care" *APTA/AOTA Joint Statement*. Available at: https://www.aota.org/tops

[2] Acumen, LLC. (2021). PAC QRP Functions TEP Summary Report. https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf

performance. In addition, we encourage CMS to allow for review and future changes to a composite functional measure as needed.

NARA requests CMS remove any unnecessary administrative burden on SNF practitioners for any quality measure implemented so that reporting requirements and patient care time can be appropriately balanced. We recommend focusing on discharge function, removing duplicative items, Core Q, and include all payer requirements that show transparency for all patients regardless of payer.

Health Equity Adjustments
We appreciate CMS looking for ways to incentivize facilities which are focusing on health equity and are providing more healthcare services to the dual eligibility population. This could help them provide additional resources that benefit the beneficiaries.

RFI: Principles for Selecting and Prioritizing SNF QRP Quality Measures and Concepts
Cognitive impairments will continue to impact the progress of the patient, and safe discharge to prevent re-hospitalization. NARA is concerned this will not be accounted for in the assessment. We also are concerned there is an absence of substantive information related to a patient's cognitive status within the SPADEs set. Although the MDS requires a combination of the BIMS, CAM, and PHQ-9 to identify cognitive status, interoperability (when available to post-acute providers) rarely gives evidence to the three screening tools to be properly combined to assure accurate identification of a patient's cognitive status. If a cognitive impairment is not identified, then a patient may not receive a needed referral for speech services thus it is important for an evidence based cognitive assessment to be completed that would include identifying executive function[3].

The cognitive assessments currently in place are not suitable to identify cognitive performance in a patient. We need to develop more contemporary tools for identifying the need for cognitive treatment. We believe cognition plays a vital role in treatment planning and appreciate CMS trying to simplify the process; however, we recommend CMS take this into consideration for future revisions. We understand cognition can be difficult to assess but we know from experience cognition impacts how we provide care to ensure best outcomes for the patient. NARA recommends CMS create a task force with appropriate providers including physical therapy, occupational therapy, and speech language pathology practitioners to devise or develop a tool or combination of tools that can identify the need for cognitive treatment in patients.

Therapy practitioners currently have a limited number of measures to consider for measuring patient outcomes. Many therapy practitioners are not as familiar with the PROMIS measures due

[3] Acumen Skilled Nursing Facilities Patient-Driven Payment Model Technical Report Dated April 2018 https://www.monterotherapyservices.com/wp-content/uploads/2018/07/PDPM_Technical_Report.pdf page 36

to the lack of application to the functions of physical therapy, occupational therapy, and speech-language pathology. There are legacy outcome measures used by therapy providers for more objective tracking as they find the PROMIS is more subjective. There would also be considerable administrative burden on providers including costs and training for therapists if the legacy measures were eliminated.

Behavioral and mental health have become more dominant underlying factors for SNF patients. This was further exacerbated by the COVID-19 pandemic. Conditions such as anxiety and depression can severely impact their quality of life. According to a study published by the National Institutes of Health (NIH), between 65% and 90% of nursing home residents have a mental disorder, ranging from common mental health problems such as anxiety and depression to serious mental illnesses like schizophrenia and bipolar disorder. The symptoms of depression in the elderly often go untreated in long-term care settings because they coexist with other health needs and can go undiagnosed. This can be especially true for residents living with comorbidities such as Alzheimer's disease or other forms of dementia. Not only can therapy treat the primary conditions of the patient but they can also address behavioral and mental health through non-pharmacological approach such as group therapy, use of memory games and puzzles, or improving their physical health so they can be more physically active.

Chronic conditions that cause pain also impact mental health in nursing homes. Pain assessment and management is critically important in SNF care and is a factor in quality care that our therapy practitioners often reference. NARA believes that services provided by therapy practitioners in significantly underutilized in the community setting and underserved/rural areas. Therapy practitioners can provide support for Medicare beneficiaries with diabetes, chronic pain, behavioral health, and provision of wellness services.

Minimum Staffing Requirements

We are looking forward to CMS' rule for minimum staffing requirements for long-term care facilities. NARA understands and agrees with CMS's correlation to some degree between staffing and the care delivered. However, despite the end of the public health emergency, the healthcare sector generally and the long-term care setting in particular continue to suffer from severe staffing shortages. There are also other factors such as social determinants of health that contribute to the ability to achieve optimal outcomes regardless of the level of care provided. There are many variables that can impact a staffing minimum standard such as census and patient acuity. As a result, **NARA recommends CMS create a stakeholder technical expert panel to discuss the development of appropriate staffing minimums and an appropriate timeline for implementation. CMS might also consider a demonstration period once the panel has drafted a standard.**

While NARA does not support establishing a minimum staffing requirement for therapy practitioners, we do believe they are an essential part of the nursing and long-term care facility

team. We would like to bring to CMS's attention that the information provided in the "Physical Therapists Staff Hours Per Resident Per Day" measure on the Care Compare website presents an inaccurate picture due to incomplete information. While the hours for all three disciplines (PT, OT, and SLP) are captured as part of the Payroll Based Journal (PBJ) reporting, only the PT hours are being reported in the measure on the Care Compare website. Currently, the PT hours posted on Care Compare do not include a clear description of what the data element is; does not explain why the other rehab therapy disciplines are not included; and is not meaningful to those using Care Compare to identify a quality nursing facility. The *Physical Therapist Staff Hours Per Resident Per Day* measure shows the average amount of time physical therapists, not including physical therapist assistants, are available to spend with each resident each day if they were treating all residents in the facility; however, not all patients receive physical therapy. CMS should consider adding language to Care Compare such as *"The quarterly reported PT staffing hours per resident day are calculated by dividing the aggregate reported PT hours by the aggregate resident census".* If CMS is going to continue displaying physical therapy staffing hours, NARA would urge them to also add the reported hours of the physical therapist assistant to this total.

NARA would like to further point out that occupational therapy and speech language pathology practitioners are essential providers treating patients on the care team and their hours represent direct care hours provided to patients in the facility, too. These hours of treatment result in the quality care provided to patients and should be reflected in the Care Compare data. Since data for all 3 disciplines of rehabilitation therapists and assistants is collected via PBJ reporting as essential members of the care team, we believe that their contribution and role in direct care should be represented as it creates the most complete picture of direct care staffing in the nursing facility for all published data. If CMS makes modifications to the existing measure in line with NARA's recommendations, reporting additional information that does not help patients meaningfully identify the quality of care will confuse, rather than empower, them.

Finally, CMS should be cognizant when establishing minimum staffing requirements that patients are receiving the care the professional was trained to provide. While all professionals working in a facility may be occasionally called upon to serve patients in ways that are not necessarily their specialty – such as feeding, bathing etc. we encourage CMS to place emphasis on the types of hours a professional spends in a facility. For example, during the pandemic and in regions where staffing shortages are particularly acute, many rehabilitation therapists have been asked to step in to provide services more often performed by CNAs. The quality of hours spent in a facility is just as important as the quantity of services being provided.

Telehealth in the Institutional Setting

NARA urges CMS to clarify and extend the use of telehealth for institutional providers including long-term care settings through December 31, 2024, to match the intent of Congress with the passing of the Consolidated Appropriation Act of 2023.

Medicare Advantage in Long-Term Care Setting

NARA recommends that CMS review in depth current practices and requirements of Medicare Advantage Organizations (MAO) to ensure Medicare beneficiaries are receiving timely and appropriate care. Many NARA members have shared deep concerns related to access to care, denials for beneficiaries, the administrative burden providers are experiencing, and consistent reductions to reimbursement rates – often lower than the Medicare Physician Fee Schedule. The recent OIG report[4] on MAOs found that MAOs did in fact delay or deny Medicare Advantage beneficiaries' access to services, even when the services met Medicare coverage and billing rules. The report also cited that some MAOs utilized clinical criteria not contained in Medicare coverage rules. While some of the denials were reversed, they cause significant delays in beneficiaries receiving care they are medically requiring; impact the achievable outcomes due to the delay in care; cause anxiety for the beneficiary for denied services they were referred for; and place a significant administrative burden on providers. Some examples from our members include:

- Ceasing to accept Humana insurance in Utah, Idaho, and Texas due to the administrative burden of requiring prior authorization followed by requesting full medical records after receiving approval to treat the beneficiary. This impacted approximately 10% of their Medicare eligible patients; and
- Remaining an out of network provider of United Healthcare (including MA plans) because reimbursement for in-network providers is approximately 20 – 25% less than the Medicare allowable from 2009 rather than 2022. Additionally, United Healthcare requires prior authorization on some plans and/or requires submission of medical records after receiving authorization. Example 1 from a member: beneficiary with Banner Health Network (an UHC plan) was denied services by an out of network provider when appealed by the patient and then by the therapy provider with the patient with documentation of why the services were medically necessary. Services were eventually approved when the referring physician also submitted a letter; however, this process took approximately 8 weeks from the time of the referral and involved several professional and administrative staff from therapy provider and the physician; and
- The length of time it takes to enroll/credential with a commercial payer offering a Medicare Advantage plan can take anywhere from 90 – 180 days. This delay causes access challenges for beneficiaries. Additionally, these payers do not retro the effective date of the contract which has financial impacts on providers. As a comparison, the enrollment

[4] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

process for a Medicare private practice group allows for a retrospective effective date within parameters and typically takes 30 – 45 days.

NARA supports the recommendations of the OIG to CMS as follows to ensure that beneficiaries who elect a Medicare Advantage plan have timely access to necessary health care services and that providers receive timely approval based on current Medicare clinical criteria, are paid appropriately, and are credentialed with plans timely to provide these services. These recommendations include:

- Issuing new guidance on appropriate use of MAO clinical criteria in medical reviews.
- Update audit protocols to address denials using updated clinical criteria guidance and denials related to billing rule.
- Hold MAOs accountable to identify and address issues with manual review and system errors.

Additionally, we request CMS to direct MAOs to process enrollment and/or credentialing applications for Medicare providers timelier and to require them to make the effective dates retroactive in line with CMS's established process. The number of Medicare beneficiaries who are enrolled in Medicare Advantage plans has grown significantly in the last several years and represents nearly 50% of the total Medicare Beneficiaries. These plans offer them additional healthcare benefits and financial flexibility. However, providers have experienced increased administrative burden and lower reimbursement compared to Medicare allowable rates, both which have been exacerbated by the struggles of post-acute care providers during unprecedented times. While NARA understands the MAOs can employ utilization management strategies that are not typically used by traditional Medicare, we believe that CMS needs to standardize the process and monitor these strategies more closely to ensure that beneficiaries are receiving timely care and providers are not burdened by unnecessary administrative work when their time is best spent treating beneficiaries.

Conclusion
Throughout our comments NARA has noted the significant impact of the workforce shortages and staff burnout on nursing and long-term care facilities. We hope CMS will take this into careful consideration when making changes to reimbursement or regulatory changes that increase administrative burden. Providers are struggling to maintain operations and care for their patients and protect the health, safety, and well-being of staff when reimbursement is continuously being reduced and penalties are being assessed. NARA members have said their staff continue to spend an excessive amount of time on administrative tasks or tasks not requiring their skillset to adhere to regulatory requirements which takes away from patient care. The healthcare worker shortage which is estimated to continue contributes to burnout which ultimately leads to risk of the beneficiary's access to care.

We thank you for the opportunity to provide comments related to this proposed rule. Should you have any questions concerning these comments, please contact Christie Sheets, NARA Executive Director at christie.sheets@naranet.org.

Respectfully submitted,

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