June 7, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1746-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically

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 National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists and speech language pathologists 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, skill 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:

Technical Updates

NARA appreciates CMS's reassessment of the market basket with new data as proposed in this rule. The use of the 2018 data is more reflective of current costs of providing services compared to 2014 data. Additionally, NARA appreciates CMS's continued analysis of the diagnosis codes and better representing of the complexities of healthcare recipients in our population.

SNF QRP Program

NARA supports updating the number of quarters used for public reporting to account for the exception to the SNF QRP reporting requirements for Q1 2020 and Q2 2020. In addition, NARA also advocates for an update to the calculation for the Transfer of Health (TOH) Information to the Patient-Post Acute Care (PAC) quality measure to omit patients discharged home under the care of an organized home health service organization or hospice from the denominator.

NARA believes adopting the new quality measure of calculating healthcare-associated infections (HAI) acquired in SNFs is a good concept, but **we urge CMS to make the data available to providers timely and at the patient level so providers can take action sooner.**

NARA supports AHCA's preliminary comment submitted on May 21, 2021 to Acting Administrator Elizabeth Richter related to the proposed new quality measure for assessing the rate of the COVID-19 vaccination among health care personnel. AHCA stated in their comment letter that the proposed HCP vaccine coverage measure appears to conflict with certain IMPACT Act provisions and is duplicative to some extent with CMS-3414-IFC published on May 13, 2021. This interim final rule relies on the requirements of participation statue and imposes civil monetary penalties for failure to report staff vaccination data. The IMPACT Act also imposes a 2% cut in Medicare rates for failure to report data used in PAC measures. Thus, **this proposed rule, and the CMS IFC creates what appears to be a penalty risk for a SNF twice for the same reporting performance incident.**

NARA supports attaining health equity for all Americans and believes this information could help support eliminating health disparities and achieving optimal health for all. It is important to create a means to assure accurate information is obtained regarding the patient's independent cognitive status and the need to ensure overall patient safety. Certain measures such as mobility status and assessments of activities of daily living can be a predictors of fall risk, cognitive decline but do not indicate when a patient has difficulty making decision, recalling essential information, and effectively communicating. Patients with cognitive deficits require a more complex plan of care due to therapeutic strategies and approaches tailored for the patient's specific cognitive level, skills, and/or abilities. **Cognitive impairments will continue to impact the progress of the patient, and safe discharge to prevent re-hospitalization and NARA is concerned this will not be accounted for in the assessment. NARA is concerned that 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. NARA is also concerned about the urban versus rural definition and would recommend adding a qualifier that identifies an area in higher need based on additional information provided such as transportation, insurance, etc.

In 2018, NARA provided the following comments related to importance of cognitive assessments in our response to the Proposed Rule, Medicare Program: Prospective Payment System and Consolidate Billing for Skilled Nursing Facilities FY 2019, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research; Proposed Rule. Federal Register, Vol. 83, No 89, Tuesday, May 8, 2018, CMS-1696-P. 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[1].

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. The following two articles support the stance that the BIMs does not predict functional cognition:

- Differentiating Levels of Cognitive Functioning: A Comparison of the Brief Interview for Mental Status (BIMS) and the Brief Cognitive Assessment Tool (BCAT) in a Nursing Home Sample https://www.ncbi.nlm.nih.gov/pubmed/24679128. "*The BIMS did not differentiate between residents with normal cognition and those with mild cognitive impairment, or between mild and moderate dementia. Both measures demonstrated high specificity and positive predictive values for identifying severe cognitive impairment or probable dementia. The BIMS had lower sensitivity and negative predictive values for identifying dementia compared to the BCAT. The BCAT accounted for an additional 47% of the variance in dementia diagnoses over and above BIMS scores*." *"Based on these findings, the BCAT appears to be more sensitive than the BIMS in predicting cognitive level for nursing home residents."*
- Screening for Functional Cognition in Post-acute Care and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014: https://ajot.aota.org/article.aspx?articleid=2647290 *"…BIMS items do not capture the capacity to use and integrate thinking and processing skills to accomplish complex everyday activities (i.e., to use functional cognition to accomplish essential IADLs).*

The Cognitive Performance Scale was retired from MDS use with the transitions to MDS 3.0 and the use of the BIMS. The combination of a dated and formerly retried screen (CPS) with the BIMS (where 15% of the patient population did not have it completed, per Acumen Technical Report) is concerning regarding the accuracy and overall validity of the findings and the true status of the patient. We understand why CMS is motivated to use current MDS data but since this has not been tested, we are not confident the results will be positive. NARA urges CMS to devise a tool or combination of tools that can identify the need for cognitive treatment in patients.

NARA appreciates CMS seeking feedback on plans to define digital quality measures (dQMs) for the SNF QRP and the potential use of FHIR for dQMs within the SNF QRP, aligning where possible

[1] 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

with other quality programs. **NARA believes the existence of interoperability from the hospital to post-acute settings will have a profound impact on the usefulness and efficacy of dQMs and the ability to provide patient-centered care throughout the entire continuum of care.** The proposed HAI measure, for example, could be captured via the patient's EHR and, with true interoperability between EHR systems, this real time data would be available to all providers to ensure the best treatment without delay.

However, there is an incredible amount of foundational data standardization that needs to occur prior to implementing a dQM system to ensure providers are capturing information in the same way and can exchange and use it to inform care. In addition, providers in the post-acute care space, including the skilled nursing facility setting, have been excluded from participation in federally funded health IT incentive programs that promote the adoption of certified electronic health record technology. As such, most EHR systems used by NARA members and SNF providers are not certified to ONC standards and in many cases, lack true interoperability.

NARA encourages CMS and the ONC to work together to address the need for an EHR certification program that takes the needs of post-acute providers and rehabilitation therapists into account and acknowledges the existing gap between the current state of interoperability in the post-acute sector and the desired state of having health IT systems support clinical decision making and quality of care with the implementation of dQMs. While NARA agrees with CMS' vision for interoperability and meaningful data exchange, attaining this goal will be an extremely complex and expensive undertaking for providers. **Therefore, NARA recommends CMS include post-acute care providers in the federally funded health IT incentive program to help a successful implementation.**

Methodology for Recalibrating the PDPM Parity Adjustment

While NARA understands and supports the expectation that PDPM was to be a budget neutral payment method, we have several concerns regarding the reliance on data primarily collected from extraordinary circumstances. While the United States seems to be through the worst of the COVID-19 pandemic, the economy and providers are still recovering from the effects of increased costs for labor and PPE, staffing shortages due to quarantines and illnesses, and temporary regulatory changes to facilitate caring for patients. NARA does not dispute that there would have been a change in therapy minutes provided between March 2020 and October 2020. During the COVID-19 outbreak, there many functions in a facility that were impacted to keep patients and staff safe including creating red zone with consistent and minimal staff treating patients to minimize spread of infection and preserve PPE, daily regulatory changes both at the state and federal level, and availability of PPE.

For these reasons, NARA requests that CMS delay any adjustments to the PDPM payment methodology until more reflective data of non-pandemic periods is available. CMS should not penalize providers for managing patient care while prioritizing safeguards to protect both patients and staff. **NARA urges CMS to assess non-COVID-19 data to determine the true impact of the change to the PDPM payment method.** There is such a minimal amount of data available

since PDPM implementation that was prior to the impact during the PHE. The information obtained during the PHE is understandably skewed.

NARA requests clarification on the calculation of the percentage of therapy under PDPM that was delivered in a group or concurrently. There seems to be confusion if the percentage noted in the proposed rule reflect the percentages of group and concurrent therapy minutes provided to all patients or the percentage of providers who delivered group and concurrent therapy. NARA believes group therapy not only helps beneficiaries in the SNF setting reach their goals but also provides them a social environment that is encouraging, positive and fosters the achievement of rehabilitation goals. NARA respectfully requests CMS to reexamine the data as it appears inconsistent with the practices within the industry prior to and during the PHE.

NARA believes the decision on what mode of therapy is most appropriate for a patient should be based on the clinical judgement of the therapist. As NARA indicated in previous proposed rules or requests for comments, CMS should not penalize all providers but rather completed individual assessments of those providers who exceed the 25% of group and concurrent therapy allowance. We also support continued monitoring of the use of group therapy once patient care returns to more normal levels.

The COVID-19 pandemic has had a significant impact on the way skilled nursing providers had to operate. The profile of patients admitted to SNFs during the pandemic is those who are much sicker with lower tolerances to services being provided than during pre-PHE periods. In addition, NARA members have noted that higher level rehab patients were discharged home rather than completing a typical SNF episode. For safety measures, many facilities needed to limit access to COVID-19 units, experienced severe shortages of appropriate PPE and significant staffing shortages. During the height of the pandemic, facilities had to creatively modify staffing patterns to provide care. As an example, many facilities relied on therapists to help assist with basic resident care and facility operations. Although NARA applauds CMS for creating waivers to allow providers to utilize Telehealth to deliver care, this was not approved until June 2020. While NARA understands that payments were not budget neutral during most of PDPM's initial year in place, the past 15 months have been an anomaly and we urge CMS to delay making any changes to payment based on the data that has been collected during the public health emergency. This data is not indicative of normal operations and making decisions that financially impact providers with this abnormal data is not appropriate.

SNF Value-Based Purchasing Program

NARA supports CMS' decision to suppress the SNF 30-Day All-Cause Readmission Measure for the FY 2022 SNF VBP Program Year due to the COVID-19 PHE affecting the measure and the resulting performance scores; updating the Phase One Review and Corrections policy to align the SNF VBP Program review and corrections policy in other value-based purchasing programs; and the technical update to the instructions for a SNF to request an extraordinary circumstance exception and to codify that update at § 413.338(d)(4)(ii).

NARA believes including measures to assess resident's views of their healthcare is a crucial part of the value-based purchasing program; however, we have concerns such as who would be completing a satisfaction survey as this could skew the data, as well as, whether there would be a required number of participants per provider for the data to be used. As we continue to experience challenging times in healthcare, NARA believes that CMS should consider delaying this type of initiative to allow the industry to return to normal levels of staffing.

Finally, NARA supports the following areas for future consideration of new measures frailty, patient reported outcomes, health equity and pain. We understand adding additional measures can create more burden for providers; however, it may to necessary to continually assess patient improvement and ensure we are meeting all the needs of our patients.

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,

Kelly Cooney, M.A., CCC-SLP, CHC
President
National Association of Rehabilitation Providers and Agencies