June 14, 2019

Seema Verma, Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1718-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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. (CMS-1718-P)

Dear Administrator Verma:

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 rehabilitative services to Medicare beneficiaries throughout the United States. NARA members furnish therapy services in all settings across the continuum of care 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 success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give it a unique insight into payment and quality programs for skilled nursing facilities. Set out below are NARA's comments on the above-referenced proposed rule.

Group Therapy Definition Change

NARA appreciates CMS redefining the definition of group in the Skilled Nursing Facility (SNF) setting so it is consistent across all Post-Acute Care (PAC) settings. A shift from 4 – 6 beneficiaries defining a group to as few as 2 will allow facilities to provide this benefit to more beneficiaries especially when a facility has a lower total skilled Part A population that makes it impossible to group four patients together for the same or similar activities or there are fewer beneficiaries with the same goals. 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 objectives. However, if finalized, NARA believes that CMS should anticipate a provider behavior change. A comparison of provider behavior prior to and after the definition change would not be equal comparisons; therefore, NARA believes that this should be factored into any analysis of behavior change.

Documentation for Group Therapy

NARA supports the need for providers to deliver appropriate justification through the documentation for the use of group therapy for beneficiaries. NARA seeks guidance on CMS' expectations for therapists when upon an initial evaluation, it is unknown when or if the beneficiary would benefit from participation in group therapy; therefore, it would not be included in the initial plan of care (POC). Moreover, since a POC is individual to each patient, providers may be discouraged from including group therapy justification for every patient when they are unable to appropriately justify group therapy. However, if the patient responds physically and mentally to individual therapy and the provider's clinical judgment is that they would then benefit from group therapy, should this be added in a progress note or should the POC be recertified?

- For example, a medically complex patient who is admitted under isolation to SNF. After a couple of weeks in the facility patient is no longer in isolation and has gained strength. The therapist's skilled assessment now shows the patient would benefit from group therapy.

How is this justification added to the medical record? NARA believes this would not be a significant change requiring a recertification of the POC but rather a modification in how the provider is using interventions to address the same goals and the same treatment diagnoses. Therefore, to require an updated plan of care as well as the burden on the physician to sign those is unnecessary and could delay the appropriate care to the beneficiary since the provider would have to wait until signatures were obtained to implement group therapy. Given shorter average length of stays, the beneficiary may miss out on this intervention. NARA requests specific guidance on CMS' expectation for proper documentation to providers and the MACs on whether the POC would need recertified or if documentation in the progress notes would be sufficient.

Updating ICD-10 Mapping and Lists

NARA appreciates the addition of publishing these lists in the SNF GROUPER software and other related products including the website. NARA would encourage CMS to ensure these updates are communicated timely, easy to locate on the website, dated so providers are able to easily identify the most current files, and a summary of what additions and deletions were made.

Initial Patient Assessment

NARA encourages CMS to consider a different name for this assessment since it might be shortened to an acronym of IPA, which would create confusion with the Interim Payment Assessment. We recommend renaming the Initial Patient Assessment to Initial Medicare Assessment which would then give it the acronym IMA.

Discharge to Community - PAC SNF QRP

NARA supports the proposal to exclude long stay nursing home beneficiaries from this measure. These types of beneficiaries have a very different discharge process back to the nursing home as a long stay beneficiary compared to beneficiaries returning to a traditional community setting. Beneficiaries returning to a community setting require more planning and coordination for discharge, which NARA believes is what this measure intends to capture. NARA recommends that CMS look at other measures for these beneficiaries, such as whether they return to prior function, improve function, or stabilize, etc., in order to determine whether the beneficiary is receiving the appropriate standard of care they need in a long-term nursing home stay.

Cognition Assessment

The cognitive assessments currently in place are not suitable to identify cognitive performance deficits that will impact levels of care and contribute to re-hospitalization risk. Additional contemporary tools for assessing mild to moderate cognitive impairment must be identified. NARA understands that cognition can be difficult to assess but experience instructs that cognition impacts how to provide care to ensure best outcomes for the patient and how it can impact risk for re-hospitalization. NARA strongly encourages CMS to take steps to identify a more appropriate assessment for identifying cognition deficits in beneficiaries. NARA recommends forming a group of subject matter experts in this area, professional/trade associations, and other key stakeholders to identify more contemporary tools or assessments.

Non-Neurologic Events Impacting Beneficiaries

NARA recommends that CMS expand coverage related to speech and patient characteristics to ensure an accurate representation of the patient by adding the following codes as speech related co-morbidities:

- R13.11 Dysphagia, oral phase
- R13.12 Dysphagia, oropharyngeal phase
- R13.13 Dysphagia, pharyngeal phase
- R13.14 Dysphagia, pharyngoesophageal phase
- R13.19 Other dysphagia, Cervical dysphagia, Neurogenic dysphagia

While these codes are considered non-neurologic characteristics of beneficiaries, the cost of treatment increases similar to those codes related to neurologic events. These codes are often used in conjunction with the neuro codes allowing for a higher level of specificity to be defined in regards to type of dysphagia present. By adding these as additional codes in the complexity portion for speech, the therapist will be able to better reflect clinical practice and skilled treatment approaches needed specific to swallowing impairment. NARA is also of the view that these should not be listed as return to provider codes.

Provider and Vendor Burdens

In the final rule CMS stated that as a result of its efforts to reduce provider burden through administrative changes, providers experienced an estimated 2 million dollars per year in decreased cost. However, NARA would like to point out new administrative burdens have been placed on providers which erodes this estimated decreased cost. Some of these include the following:

- Additional documentation requirements and data capture for beneficiaries who are not Medicare beneficiaries on the MDS;
- Administrative burdens imposed by Medicare Advantage Plans require additional oversight . Examples include, (1) Payer-specific formats for daily or weekly updates of beneficiary's functional status that exceed Medicare requirements; (2) Pre- and Post-payment medical review processes inconsistent across Medicare Administrative Contractors (MACs); (3) inconsistent denial reasons across MACs and inconsistent with Medicare standards; (4) application of the improvement standard which is out of compliance with the *Jimmo vs Sebelius* ruling, but requires providers to expend time and resources to appeal these denials though at a minimum 3 levels; and (5) increasing burden for EMR vendors who have to accommodate the varying standards which invariably results in downstream increased costs to providers;
- Transfer of Information: Currently hospitals are not required to provide patient diagnosis information to post-acute care providers which makes it difficult for PAC providers to include that information in the medical record. NARA encourages CMS to finalize the hospital discharge requirements and include the requirement for them to transfer patient diagnosis information to subsequent providers as other post-acute providers are required to do. By doing so, the PAC providers would have decreased administrative burden by using resources more effectively in the admission process by not having to contact the hospital multiple times to obtain this information. Possibly assess this by including a checkbox on the MDS to indicate whether the information was received from the previous provider. Additionally, NARA encourages CMS to consider the increased burden and costs for EHR vendors, and indirectly providers, that lie in the multiple step process of ONC Health IT Certification process as related to this measure.

Additional Comments

Regarding the Fee Schedule Adjustment, rural providers receive an adjustment based on the location of their services; however, other more urban facilities with a significant population of underserved or Medicaid beneficiaries should be considered for a risk adjustment. They often deal with beneficiaries with multiple co-morbidities who have not had access to healthcare

services or may not have a consistent or stable living environment causing a longer length of stay due to non-existent or very limited discharge options. They are at significant risk for monetary penalty under the quality payment program.

Should you have any questions concerning these comments, please contact George G. Olsen, Esq. at ggolsen@wms-jen.com.

Respectfully submitted,

Stephen Hunter, PT, DPT, OCS
President
National Association of Rehabilitation
Providers and Agencies