



June 10, 2022

Chiquita Brooks-LaSure, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1765-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 2023 (CMS-1765-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:

**Market Basket Update**

NARA appreciates CMS's reassessment of the market basket but urges 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, staffing shortages and the cost of complying with the increased COVID safety measures. The market basket update should be reflective of the actual cost of delivering services to our nation's most vulnerable population; while an increase of 3.9 percent is appreciated, it does not cover the actual increase in costs for nursing facilities.

### **Patient Driven Payment Model (PDPM) Parity Adjustment**

In October 2019, CMS implemented the Patient Driven Payment Model (PDPM) under the SNF PPS, a new case-mix classification model that replaced the prior model, the Resource Utilization Groups, Version IV (RUG-IV). CMS designed PDPM to be implemented in a budget neutral manner so that the aggregate amount of Medicare Part A payment to SNFs would remain stable despite the change in payment models.

In the 2021 rule, CMS indicated the need to implement a parity adjustment to maintain budget neutrality but delayed implementation of an adjustment to ensure the effects of the COVID-19 pandemic were not the driver of cost increases, rather than the payment model itself. In the 2022 Proposed Rule, CMS recalibrated its methodology for calculating the parity adjustment and proposes to lower the PDPM parity adjustment factor from 46 percent to 38 percent for each of the PDPM case-mix adjusted components. This methodology would result in an estimated reduction in aggregate SNF spending of 4.6 percent, or approximately \$1.7 billion.

**While NARA understands and supports the expectation that PDPM was to be a budget neutral payment method, we have several concerns with the timing of the proposed parity adjustment to providers who continue to struggle financially during the ongoing COVID-19 PHE. NARA recommends CMS reconsider the methodology used until non-PHE data can be used or phase the adjustment in over several years.** NARA disagrees with the idea that an overpayment is occurring between the transition from the RUG-IV model to the PDPM model because there has been a change in care needs and providers are able to document the complexities of the patient better under the new payment model. One of the purposes for implementing PDPM was to capture all patient characteristics impacting the patients' health and well-being more accurately. These characteristics were previously not captured by the MDS under the previous RUGs payment system.

NARA understands that payments have not been budget neutral since PDPM's implementation, but the past 28 months providers have been struggling with the impact of the COVID-19 pandemic on patient care and operations. The data collected during this public health emergency is not indicative of normal operations and making decisions that financially impact providers with this abnormal data has an unfair negative impact on providers. The profile of patients being admitted to nursing facilities tend to have more acute conditions, experience lengthy isolation, suffer from the effects of "long COVID" or are without the community support needed to immediately return home. These types of patients cost the system more to care for and facilities should not be penalized for providing appropriate care for all types of patients admitted to their facilities because coding under PDPM paints a more accurate picture of a patient's characteristics and burden of care compared to the limitations of the previous system.

NARA strongly disagrees with CMS's current proposal to implement the entire parity adjustment in a single year. **We oppose the burden of budget neutrality because nursing facilities have**

**endured continuous reimbursement reductions, significant changes in regulations and unprecedented and overwhelming staffing shortages which combined do not help providers overcome current obstacles. If CMS were to move forward with this implementation of this parity adjustment, NARA requests a phase-in period of two or three years after the PHE has ended.** As providers face higher costs, any payment reduction puts additional strain on many providers and facilities which may result in an access to care issue as we prepare for the coming “silver tsunami” of the Baby Boomer generation.

While the United States seems to be through the worst of the COVID-19 pandemic, the impact on the economy and providers is still being felt acutely by nursing facility. They are still trying to recover from the effects of increased costs for labor – use of registry staff for nursing and therapy – and PPE, severe staffing shortages, and regulatory changes to facilitate caring for patients. According to the Bureau of Labor Statistics (BLS) as compiled by American Health Care Association (AHCA) and National Center for Assisted Living (NCAL), between January 2020 and January 2022, nursing and residential care facilities lost nearly 410,000 employees as seen in Figure 1 below

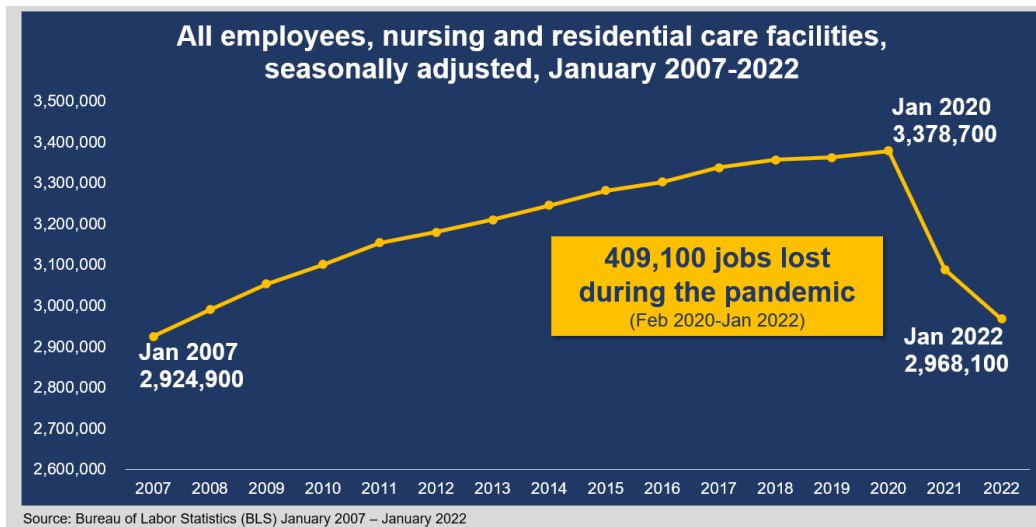


Figure 1

Additionally, the BLS data indicates that assisted living, community care facilities for the elderly, and nursing care facilities employment rates have continued to dip through January 2022 while physician offices, outpatient care centers, home health, and hospitals have rebounded and returned to March 2020 employment levels or higher as seen in figure 2

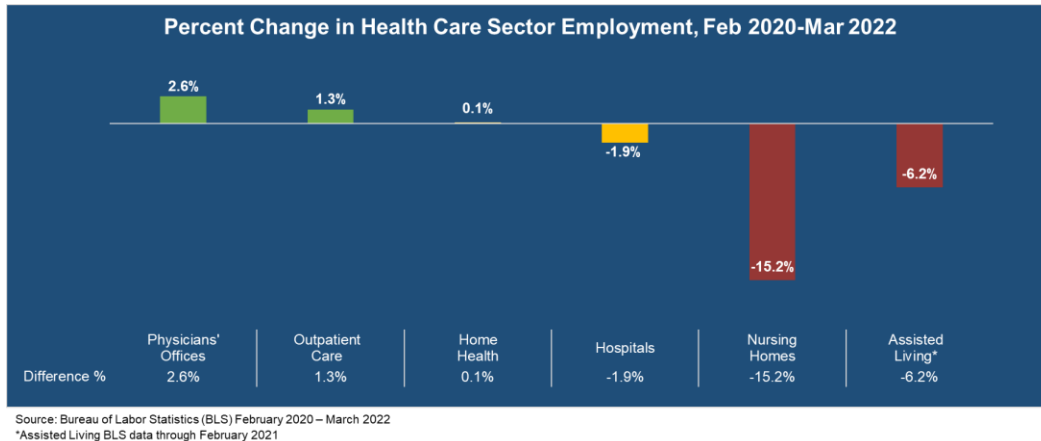


Figure 2

Nursing home and assisted living facility providers have yet to recover from the mass resignations of 2020 and 2021 caused by the mental and physical burnout, fear, and additional regulations of the pandemic. This staffing shortage has resulted in significant cost increases associated with utilization of registry staff, over time recruiting new staff, and retaining current staff. NARA urges CMS to consider the economic and severe workforce shortages currently being experienced by nursing home providers before reducing reimbursement.

### Methodology for Applying the Recalibrated PDPM Parity Adjustment

In response to CMS’s technical questions regarding the implementation of the parity adjustment, NARA supports applying the parity adjustment equally across the CMIs.

### Proposed Changes in PDPM ICD-10 Code Mapping

We do not support changing F32.A, “Depression, unspecified” or M54.50 “Low back pain, unspecified” to “Return to Provider”. We acknowledge providers do have a greater understanding of identifying what is causing the low back pain and should be able to code a more specific diagnosis to address the condition; 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.

### RFI: Minimum Staffing Requirements

In the proposed rule, CMS states it intends to establish minimum staffing requirements for long-term care facilities in the future. While currently undefined, CMS seeks feedback on addressing direct care staffing requirements, especially those for registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs), colloquially known as nurse aides, through the requirements for participation for LTC facilities. NARA would like to point out that other providers such as rehabilitation providers (physical therapists, occupational therapists, and

speech language pathologists) are mandated to provide direct care to residents when needed to ensure residents are receiving appropriate care. NARA understands and agrees with CMS's correlation to some degree between staffing and the care delivered; however, once the public health emergency ends it does not mean that the staffing shortage challenges end. 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. **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 providers, 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 does 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.

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.

### **Nursing Home Staff Turnover Measure**

NARA understands the concept behind this measure; however, we do not believe that now would be the appropriate time to implement such as measure. The data retrieved from CMS's PBJ System does not account for temporary staff, changes a provider may make in their payroll or human resource system, or extended leaves of absence. Again, we emphasize that providers are still dealing with workforce challenges and any potential penalty to reimbursement hinders progress being made in stabilizing staffing numbers.

### **SNF Quality Reporting Program (SNF QRP)**

For the FY 2023 SNF QRP, CMS is proposing to revise the compliance date for the Transfer of Health (TOH) Information to the Provider-PAC measure, the TOH Information to the Patient-PAC measure, and certain standardized patient assessment data elements (SPADEs) from October 1st of the year that is at least two fiscal years after the end of the COVID-19 PHE to October 1, 2023. NARA supports revising the compliance date; however, we do have concerns with timing for release of the newer version of the Minimum Data Set (MDS) 3.0 and the ability for providers and health IT developers to implement, develop and prepare software for the new version and the new reporting requirement simultaneously.

As part of amending the compliance date for these measures and data elements, CMS is proposing to adopt a newer version of the MDS 3.0 (specifically, MDS 3.0 v1.18.11). We know it has been CMS's desire to remove Section G from the MDS and move to Section GG, which contains data elements that are standardized across post-acute care settings. While this may appear to reduce some administrative burden for providers, there are many state and other programs that may continue to use data elements from Section G which may lead to these programs creating their own assessment for items currently reported in Section G to satisfy their payment systems. The result of this would require IT vendors to program a multitude of additional forms. NARA supports the move to the standardized Section G but encourages CMS to keep in mind other payment systems that utilize MDS data when it considers changes to SNF regulations and requirements.

Additionally, anytime CMS is adopting a new version of the MDS it must give the health IT developers adequate time to develop, test, and deploy new software. In the past, health IT developers have indicated they need a minimum of 18 months for this process to occur effectively. Providers will also need time to update their systems and train employees on any

changes. For these reasons, NARA urges CMS to provide information on a new version of the MDS as soon as possible and to provide adequate lead time to IT developers and providers.

For the FY 2025 SNF QRP, CMS is proposing to adopt the measure Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431). NARA supports the idea of reporting HCP influenza vaccination coverage, but we request CMS clarify some of the details of the data reporting threshold. According to the proposal, there is an additional data reporting threshold under the SNF QRP which must be met to avoid a 2 percent withhold penalty. The SNF QRP currently has an 80 percent reporting standard, and the new proposal would add a 100 percent reporting standard for measures reported through the Center for Disease Control's (CDC) National Health Safety Network (NHSN). Providers must be compliant for both thresholds to avoid the 2% penalty. NARA requests CMS clarify what "100 percent" reporting means for the CDC measures: does it mean filling out and submitting the form or does it mean reporting on 100 percent of persons who meet the eligibility of the measure. Additionally, we ask CMS to provide additional information on how this reporting will be validated so facilities and providers can ensure they are complying and reporting correctly. Because this measure needs additional clarification and can result in a provider losing 2% of reimbursement, we recommend CMS delay moving forward with this measure until clarification can be provided.

**RFI: SNF QRP Quality Measures under Consideration for Future Years**

In the proposed rule, CMS is seeking information on the importance, relevance, and applicability of a composite, cross-setting functional measure that would incorporate the domains of self-care and mobility. While we are supportive of the overall concept of a future cross-setting functional measure, we believe that the risk-adjustment formula must be appropriate and the item sets for both self-care and mobility be fully taken into consideration. We encourage CMS to bear in mind that while these measures are cross-setting functional measures, the results cannot be compared from setting to setting because each item is setting specific and patient dependent<sup>1</sup>; however, NARA does believe many of the self-care items could be applicable to the four settings. We encourage CMS to consider measures that are most appropriate for each unique setting based on the type of patient in the setting in future rule making.

CMS is also seeking input on the value of a COVID-19 Vaccination Coverage measure to assess whether nursing facility patients are up to date on their COVID-19 vaccine. Recently, the CDC made changes to its policy to require both providers and ancillary service providers to continue expensive routine COVID testing of staff. When the CDC changed their definition of vaccination status from "fully vaccinated" to "up-to-date," which included at least one booster, it caused an additional burden on providers. While we do not disagree on the importance of vaccine coverage and routine testing, we want CMS to be aware there is a significant cost in resources when these types of changes are made. Providers also have additional resource costs to monitor the CDC

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<sup>1</sup> <https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf> page 17

map showing the status of counties around the country as they change from green to red or orange and back and the changing corresponding testing requirements for staff who work in those counties. The impact of the cost of these resources is felt significantly by ancillary service providers, who were not eligible for Provider Relief Funds (PRFs) because their services are billed to CMS directly by the nursing facility under consolidated billing requirements.

#### **RFI: Inclusion of the CoreQ: Short-Stay Discharge Measure in Future SNF QRP**

CMS is requesting information on the potential inclusion of the *CoreQ: Short Stay Discharge Measure in the SNF QRP* for the future. CMS is considering this as part of the Meaningful Measures initiative, as the measure focuses on patient reported outcomes and patient satisfaction. NARA supports a patient satisfaction measure in the SNF QRP.

#### **SNF Value-Based Purchasing Program**

NARA agrees with the addition of the following measures:

- The Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI) is an outcome measure that assesses SNF performance on infection prevention and management; however, this measure is not support by NQF and NARA would encourage CMS to only include in the VBP measures approved by NQF; and
- The Adoption of the Discharge to Community – Post Acute Care Measure for SNFs (DTC) is an outcome measure that assesses the rate of successful discharges to community from a SNF setting.

We do not support the implementation of the Total Nursing Hours per Resident Day measure to be implemented in FY2026. Since the baseline data will be FY2024, it is difficult to predict what the state of the staffing shortage will be then. This information is currently being collected and impacts the Five-Star Quality Rating System.

#### **Health Equity Request for Information**

NARA supports collecting data for measures of social determinants of health; however, as this is an administrative burden, this may not be the most appropriate time to add an additional requirement and potential penalty to providers.

#### **Expanding Criteria for Coding Infection Isolation**

NARA supports expanding the current criteria for coding infection isolation to allow cohort patients to be included and to ensure that the payment rate impact of infection isolation is consistent with the increase in relative costliness associated with the patients. Per the STRIVE Study, when a provider isolates two patients in the same room the same amount of staff time and resources are used to care for each patient regardless of whether they are in a single or shared room. The impact of isolating a patient and moving them to a new environment greatly influences the psychosocial well-being of the patient which can have a negative result on their outcomes. NARA encourages CMS to not reduce reimbursement based on the ability to cohort patients in isolation when appropriate.



### **Other Recommendations for CMS**

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<sup>2</sup> 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. Additionally, these payers do not retro the effective date of the contract. The enrollment 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

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<sup>2</sup> <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>

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 retrospect effective dates like CMS's established process. The number of Medicare beneficiaries who are enrolled in Medicare Advantage plans has grown significantly in the last several years. 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 which has been exacerbated by the struggles of post-acute care providers during unprecedented times. While NARA understands that the MAOs can employ utilization management strategies that are not typically used by traditional Medicare, we believe that CMS needs to 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 and we hope that CMS will take this into careful consideration when making changes to reimbursement or regulatory changes that increase administrative burden. In the recent advisory from the US Surgeon General<sup>3</sup>, some of the topline recommendations for addressing staff burnout include protecting the health, safety, and well-being of all health workers; reduce administrative burdens to help health workers have productive time with patients, communities, and colleagues; and invest in public health and our public health workforce. Providers cannot protect the health, safety, and well-being of staff when reimbursement is continuously being reduced and penalties are being assessed without providing support or appropriate reimbursement. NARA members have expressed that their staff continue to spend an excessive amount of time on administrative tasks or tasks not in the scope of their practice to adhere to regulatory requirements which takes away from patient care capacity. The healthcare worker shortage which is estimated to continue contributes to burnout which ultimately leads to the beneficiary's access to care.

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<sup>3</sup><https://www.hhs.gov/surgeongeneral/priorities/downloads/health-worker-burnout-advisory.pdf>

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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](mailto:christie.sheets@naranet.org).

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Kelly Cooney". The signature is fluid and cursive, with the first name "Kelly" and last name "Cooney" clearly distinguishable.

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