NARA
The National Association of Rehabilitation Providers and Agencies

August 27, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Term Care Hospital Quality Reporting Program Requirements (CMS-1747-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, skilled nursing facilities, assisted living facilities, retirement communities, hospital inpatient and outpatient, and in the beneficiary's home. As a member-driven organization, NARA promotes best practice 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 home health providers. We appreciate the opportunity to provide the following comments related to the above proposed rule.

We appreciate that occupational therapists will be able to perform the initial and comprehensive assessments required to open Medicare home health therapy cases on a permanent basis as of January 1, 2022. Due to the level of education and competence of occupational therapists and the beneficial service they provide, we ask CMS to consider allowing for an occupational therapist to function as the sole provider of a home health case when appropriate. An occupational therapist provides services that are integral to the activities of daily living, safety, and level of independence of beneficiaries. Thus, occupational therapy skilled services are an ideal match for

many homebound beneficiaries even when there may not be a need for another discipline to be involved in the case.

We appreciate CMS beginning the collection of data on two measures promoting coordination of care in the home health quality reporting program effective Jan. 1, 2023, as well as measures under long-term care hospital and inpatient rehabilitation quality reporting programs effective Oct. 1, 2022. We believe the continuous assessment of measures and identifying of new measures allows the best opportunity to collect the best quality data on beneficiaries.

We also appreciate the payment increase of 1.8% for home health agencies that have submitted required quality performance data.

Patient-Driven Groupings Model (PDGM) and Behavioral Assumptions

NARA understands and supports the expectation that the Patient-Driven Groups Model was to be a budget neutral payment method, and we appreciate CMS not making any payment adjustments due to the public health emergency (PHE) in the proposed rule for CY 2022. We would like to offer comments related to the behavioral assumptions. During the COVID-19 outbreak, there were many functions within healthcare systems impacted as a result of providers taking measures to keep beneficiaries and staff safe. These measures included but were not limited to minimizing the number of staff who treated a unique beneficiary in order to minimize the spread of infection and preserve personal protective equipment (PPE); the elimination of elective surgeries; regulatory changes occurring almost daily at both the state and federal level; and availability of PPE. The proposed rule noted that more beneficiaries were classified in the high impairment category than was originally projected. We believe this is directly related to the PHE, rather than provider behavior. Beneficiaries who typically would have been discharged from the hospital to a skilled nursing facility were being discharged to their homes or the homes of family members with home health services. These patients demonstrated a higher acuity, and therefore, a higher functional impairment.

Additionally, table 3 in the proposed rule indicated there was a drop in the number of visits provided by physical therapy, occupational therapy, and speech therapy as compared to CY 2019. This too can be directly attributed to the PHE. For example, hospitals paused elective surgeries and any non-emergent services in order to preserve PPE, maintain surge capacity, and reallocate resources. In addition, some beneficiaries minimized or refused therapy services in their home due to their concern of contracting COVID-19. Finally, to limit the risk of exposure, many assisted living facilities implemented a 'no visitor' policy, which sometimes restricted therapists from providing care to its residents.

CMS Procedure Issue Comments

NARA would also like to comment on the reported decrease in speech therapy visits. Historically, NARA members feel speech-language pathology involvement in a home health plan of care has been underutilized and Quality Improvement Measures have often lacked the focus to address

speech, language, and cognitive challenges for analysis and trending. This oversight tends to direct providers to providing those disciplines that specifically address and can advance areas that are tracked and publicly reported such as walking and bathing. This leaves those important areas of communication, swallowing, and cognitive linguistic deficits to be delayed at best or under treated at worst. We believe that M1710 When Confused in OASIS D1 could be used to analyze the impact of confusion on outcomes and transition plans. Such crucial areas that impact the aging population are not being sufficiently scrutinized to draw conclusions as to whether they are receiving adequate attention in home care with positive outcomes. We urge CMS to elevate those communicative, swallowing, and cognitive components to a higher scrutiny to improve the beneficiary's quality of life.

In addition, NARA expresses concern with CMS' statement from the 2019 Home health proposed rule released in 2018 on page 207 that stated as cognition declines the resource use also declines. NARA members are troubled with this information and data which can belies an underlying issue. Experientially, we recognize that when a patient's cognition declines, it should invoke a care plan to further caregiver education analysis of the change in cognition on the functional performance of the patient and incorporate the patient's abilities and disabilities. These skilled speech therapy interventions can help promote an individual to function as independently and safely as possible, extend his or her ability to age in place and decrease caregiver burden. This known need does not appear to be in line with the data that shows a decline in resource use and CMS dollars spent. A simple regression analysis of spending does not provide insight into missed patient needs. We encourage CMS to look at research evidence supporting continued clinical intervention with progressive cognitive decline rather than relying solely upon statistical analysis of resource use and dollars spent.

Expansion of Value-Based Purchasing Model

We support expanding the value-based purchasing model to all states based on the yielded results in quality scores and annual savings reported by CMS. This model aligns value with reimbursement through measuring performance. However, NARA believes the model should be changed to allow a true shared savings approach rather than just expanding the model. For example, instead of applying a negative adjustment to lower performing agencies to give a positive adjustment to higher performing agencies, consider spreading the savings based on improvement of quality scores and savings by that provider.

Supervisory Visits with Aides

During the public health emergency, CMS allowed mandatory supervisory visits with aides to be performed virtually; the proposed rule would make this change permanent but would limit virtual supervision to no more than two virtual assessments in a 60-day period. NARA supports this change to allow for permanent ability for virtual supervision; however, we feel this change is too restrictive to make a significant impact. Based on the information provided in the proposed rule, it appears the limit of two virtual assessments is applicable per home health agency and not per patient. This is not aligned with other post-acute settings with this type of visit. For example, the

skilled nursing facility setting has no limit on virtual supervisory visits. NARA understands the desire to ensure virtual supervision complements but does not replace in person supervision. However, we request CMS consider allowing up to two home health (HH) aide supervisory visits per beneficiary to be performed virtually. Virtual supervision allows greater involvement from a skilled supervisor; at this suggested level, would help provide some mitigation to the registered nurse shortage; and when appropriate technology is available, can improve and increase beneficiary access. We urge CMS to consider changing this allowance from per agency to aper beneficiary.

Health Equity Feedback

CMS also included two Requests for Information in the CY 2022 HH Proposed Rule. NARA would like to provide comment on behalf of its members on both.

The Fast Healthcare Interoperability Resources (FHIR) in support of digital quality measurement in post-acute care QRP. CMS is considering adopting a standardized definition of dQMs in alignment across the HH QRP. NARA is supportive of any policies that would advance interoperability among its providers. Home health agencies often struggle with obtaining comprehensive medical records and spend an inordinate amount of time on the phone and emailing hospitals, other post-acute care providers, and physicians to obtain additional information. Some agencies are fortunate to have electronic access to hospital records, but because home health agencies (HHA) were not included in the Health Information Technology for Economic and Clinical Health (HITECH) Act which awarded incentive money to providers who made advancements in the adoption and use of interoperable information technology and electronic health records, most do not have the financial ability to invest in these types of systems CMS posed the question, "what ways could we incentivize or reward innovative uses of HIT that could reduce burden for PAC settings", and providing incentives is one way. Those incentives could be financial, or they could be points that are awarded through the HH VBP program. CMS also posed the question about "what additional resources or tools would HHAs find helpful to support testing, implementation, collection, and reporting of all measures using FHIR standards?" HHAs need to have the opportunity to participate through a venue that is appropriate for post-acute care (PAC) settings. Many of the health IT vendors do not understand the PAC space, and therefore are not willing to make changes conducive to the kind of requirements HHAs must abide by. Providing opportunities for larger HHAs to work with smaller HHAs in a demonstration or pilot would help bring all HHAs along.

Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs. NARA appreciates CMS addressing this issue and asking for feedback. NARA members are quite aware of the disparities and inequities that exist throughout the healthcare system since many of our members directly work with these beneficiaries in finding community-level solutions. As stated earlier, NARA is supportive of CMS' decision to begin collection of the social determinants of health (SDOH) standardized patient data elements earlier than originally planned since we believe this information will help to inform future care processes. In the meantime, members

would be supportive of CMS' suggestion to provide confidential feedback on HHA-level quality measure results stratified by social risk factors that are currently available. In response to CMS request for information on using risk adjustment methodologies for quality measures in the future, NARA would ask that CMS involve stakeholders in any future discussions about this. Risk adjustment methodologies using SDOH could have unintended consequences of lowering expectations for quality of care. Therefore, any future use of the data should be carefully thought out.

Miscellaneous Comments

We also recommend that CMS remove the 30-day reassessment requirement for therapy services. This practice was in place as a requirement in the past due to visit counts and thresholds. We believe removing this requirement will align more with nursing requirements that this 30-day reassessment is not required and the "recertification, supervisory" requirements for therapy should mirror our nursing colleagues.

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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President
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