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May 28, 2024

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 2025 (CMS-1802-P)

Dear Administrator Brooks-LaSure:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 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 a 4.1% net increase in payment rates, marking the second consecutive year of such increases, which is encouraging. However, the forthcoming staffing mandate will offset these gains significantly for Fiscal Year (FY) 2024 and FY 2025. Additionally, while appreciated, this increase falls far short of covering the actual rising costs for nursing facility operators.

We support the Centers for Medicare & Medicaid Services (CMS) proposal to update the SNF market basket base year from the current 2018 base year to a new base year of 2022 and to update the payment rates used under the SNF PPS based on the FY 2025 SNF market basket increase factor, as adjusted by the productivity adjustment and forecast error correction. While

non-healthcare businesses can increase their rates to customers, the healthcare industry lacks this ability. Nursing facility providers continue to struggle with inflation and staffing shortages, while CMS continues implementing additional regulations and penalties. Although we understand the intent behind the staffing mandate, CMS' timeline does not reflect an awareness of providers' ability to manage the lack of available staff to hire or the heightened staffing costs. Given the disparate payment rates SNFs' are left to manage between Medicare, Medicare Advantage, and state Medicaid funding, it is a struggle to adequately cover these expenses.

Request for Information on Potential Future Updates to the Non-Therapy Ancillary Component
NARA supports the addition of G0600D: Mobility Devices: Limb prosthesis, I6100: Active Diagnoses: Post Traumatic Stress Disorder and I5900: Active Diagnoses: Bipolar Disorder to the Non-Therapy Ancillary Component (NTA). These conditions *do* increase the cost of care and require additional resources.

Additionally, we disagree with the reduction of I6200. Active Diagnosis: Asthma, COPD, Chronic Lung Disease from 2 points to 1 point. According to a 2020 article in Respiratory Medicine,[1] COPD is a leading cause for unplanned hospitalizations and readmissions around the world. Asthma and COPD patients require maintenance and rescue medications. Daily skilled nursing assessments and evaluations are needed to prevent exacerbation. Additional equipment and medications must be readily available to treat patients with these conditions to reduce hospital burden. Having access to respiratory therapy or other specialty providers that have specialized training to identify any potential trends or signs of decline is imperative with reducing and preventing exacerbations.

In conclusion, these beneficiaries are generally medically complex. While in some cases, the data may demonstrate a lower cost of care, it is the cumulative effect of additional medical complications that frequently exist in these patients that may result in significantly increased costs associated with providing care to these beneficiaries. We recommend CMS does not change I6200 to 1 point but rather keep it as 2 points, demonstrating the complexity of patients with Asthma, COPD, and chronic lung disease.

Proposed Changes in PDPM ICD-10 Code Mapping
NARA supports CMS' proposal to update any non-substantive changes to ICD-10 code mappings and lists used under PDPM through a subregulatory process. This would involve 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 website in a manner that is easy to find. Furthermore, the updates should clearly identify the changes with specific effective dates that are reasonable for skilled

[1] Risk Factors and Associated Outcomes of Hospital Readmission in COPD: A Systematic Review https://www.sciencedirect.com/science/article/pii/S0954611120301281

nursing facility (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.

Nursing Home Enforcement

NARA supports methods of ensuring beneficiaries receive safe quality care during their stays at a nursing home. However, we believe that expanding the civil money penalties (CMPs) to allow more per instance and per day CMPs to be imposed may only exacerbate an already challenging situation for a facility. These additional penalties along with the implementation of staffing mandates are going to only make an already challenging situation even more unmanageable and may lead to facility closures, leaving beneficiaries without access to care. We encourage CMS to be more proactive in assessing these situations and determine the root cause of non-compliance. Nursing home operators have faced significant reimbursement cuts, a new payment system, a pandemic and rising operating costs. We believe it is inappropriate to impose additional penalties, particularly when these operators are already struggling. We believe CMS should work with providers to better understand the challenges of managing day- to- day operations amid staffing shortage and high inflation.

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 beneficiary outcomes that can be achieved through the delivery of physical therapy, occupational therapy, and speech language pathology practitioner's services. We encourage CMS to take into consideration that hospitals are required to collect data related to a beneficiary's social determinants of health (SDOH) and this information could be shared with post-acute care providers, including SNFs, if they were incentivized or mandated to do so. However, since post-acute care providers, including SNFs, were not included in the HITECH interoperability incentives, then under CMS' proposal, they would be burdened with the requirement to collect this data even when discharged from the hospital. Therefore, we recommend that SNFs not have to collect this information upon admission but rather upon discharge for discharge planning.

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.

QRP MDS Validation Process for FY2027

NARA understands this requirement was mandated by the Consolidated Appropriations Act of 2021; however, we urge CMS to recognize that this process will create an additional

administrative burden for providers. We seek clarification on the following questions related to this process:

- How will providers provide medical records? Portal, fax, secure email?
- How will CMS provide confirmation to the provider of receipt of records?
- How will providers be notified that they have been randomly selected for validation?
- CMS indicated that they would be proposing processes for review in future rulemaking NARA urges CMS to ensure the reviews are done in a fair and equitable manner. This would include having therapy professionals on the review team when therapy services are provided, since they alone would be able to validate the functional components associated with SNF QRP measures.
- NARA also strongly urges CMS to have appeals process whereby SNFs may appeal inconsistencies between reviewers to ensure equitable reviews.

NARA encourages CMS to ensure the process for the QRP MDS Validation process is clarified and a method of ensuring patients over paperwork is in place.

Skilled Nursing Facility Quality Reporting Program: Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements and To Modify One Item

CMS is proposing to add for FY2027 (admits as of October 1, 2025) collection of four new items as standardized patient assessment data elements under the SDOH category: one item for living situation, two items for food, and one item for utilities and modifying transportation. Overall, NARA supports the collection of standardized assessment data elements which have been identified as impacting case mix, cost, and outcomes for beneficiaries and would further inform the health equity challenges across the continuum of care. However, our members have expressed concern about the administrative burden associated with collecting this data when it is already required by hospitals via the IQR requirement to screen for SDOH.

CMS has dedicated considerable time and resources to advancing interoperability. Despite this focus, there has been minimal progress within the post-acute sector. Enabling access to information pertaining to SDOH and other patient characteristics embedded in interoperability standards could significantly reduce administrative burdens for post-acute providers. NARA urges CMS to continue advancing interoperability capabilities across the continuum of care including funding sources for all providers to reduce administrative burden and provide patient data across all settings for better outcomes. Additionally, we request consideration for residents returning to the SNF and inclusion of a skip pattern for the questions or notation that their living conditions post SNF discharge are to remain in the SNF.

Collection of Information Requirements on the MDS

NARA disagrees with the removal of MDS items collecting therapy minutes over the last 7 days, therapy start date(s), and therapy end date(s): O0400.A.2 through O0400.C.6 on the MDS 5-day PPS assessment beginning October 1, 2025. By removing the therapy start date we could lose

Commented [ES1]: Is this asking how providers will be notified of that they need to send in records? Or how they will be notified the records have been received?

Commented [CS2R1]: How providers will be notified of the records request.

Commented [ES3R1]: OK modified to specifically ask that question

Commented [ES4]: Didn't CMS say they would propose this? But welcome new ideas? Do we have ideas?

See: https://www.federalregister.gov/d/2024-06812/p-437

Commented [CS5R4]: Do we combine the 4th and 5th bullet?

Commented [SM6R4]: I am in favor of that

Commented [ES7R4]: Modified to capture this....welcome feedback.

Commented [ES8]: I am not sure what this means. Can you clarify?

Commented [CS9R8]: I think this was added by Diane and that it means that if the reviewers happen to not be of the same discipline then it might not be equitable

Commented [ES10]: Just a thought for others to weigh in on

Commented [SM11R10]: I agree

Commented [ES12]: Is this header duplicative of the previous one? Or meant to indicate something different related to the QRP?

Commented [CS13R12]: Separate from the previous one

Commented [ES14]: Is this referring to the IQR requirement to screen for SDOH? If so, should we state that specifically?

Commented [CS15R14]: Yes, my apologies I will add that

Commented [ES16]: It is unclear to me what this is saying.
Are we saying that PACs should have access to data collected in hospitals?
If yes, how?

Commented [CS17R16]: When CMS first started the interoperability they made funding available to eligible

Commented [ES18]: Is this related to the proposed 4 new SDOH items? We haven't said that anywhere, so I am

Commented [CS19R18]: Updated the paragraph & heading

access to data that will impact outcomes. The ability to determine how quickly therapy evaluates a beneficiary is a good prognosticator of a positive outcome. A significant number of patients are admitted to SNF because they require daily skilled rehabilitation and require prompt evaluation (i.e. start dates) of therapy. Without the information provided by these items in Section O, the ability to monitor prompt therapy involvement in those cases is diminished.

While these items may no longer be needed in the case mix adjusting of the per diem payment for PDPM, they do trigger the SNF to consider a beneficiary's need for additional appropriate services. CMS acknowledged in the proposed rule that they believe these items are completed by a RN and LPN/LVN. NARA agrees, but also knows that these are individuals who may rely on "triggers" to think about other specialized staffing resources that should be utilized to ensure a beneficiary achieves the best outcomes in a timely fashion. We believe that if CMS removes these items, it signals a devaluing of the role of therapy in the care plan of a beneficiary.

On the contrary, this is an opportunity for CMS to collect data on the use of therapy in the SNF setting. Therapy is an essential component of a beneficiaries' recovery and should not be diminished. If CMS does not require the data to be reported, then it gives the appearance that the information is not important in understanding the beneficiary's recovery and may inadvertently result in inadequate care. While the minutes may no longer drive payment, the information provides important information related to patient care and serves an important role in health services research. We strongly urge CMS not to remove these items from the MDS as it could remove the incentive to support interdisciplinary team communication that would negatively impact the progress of the beneficiary.

Commented [ES20]: This seems to be 'extra' language that has already been stated, but defer to others.

Commented [CS21R20]: Yes, it is. I added it twice to make a restate the point.

Medicare Advantage in Long-Term Care Setting

NARA strongly recommends CMS provide more oversight with 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 OIG report[2] 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. NARA appreciates the steps that CMS has taken to ensure appropriate services are being provided without unnecessary barriers; however, we believe CMS should continue needed oversight to ensure all MAO's are adhering to the recent rules and current guidelines in place.

Commented [ES22]: Do we have additional suggestions other than what has been published in the Final Rule? Or is this a holdover from previous comment letters?

Commented [CS23R22]: Hold over from previous comment letters. I left it for suggestions/recommendations from group; however, we can eliminate. I thought the group wanted to make sure CMS continued to provide oversight even beyond just creating the rules.

Commented [SM24R22]: I feel like it is fine to keep because of how it is worded

Credentialing Barriers with MAOs

NARA continues to hear from our members about closed networks and obscenely lengthy credential/contracting processes with a commercial payer offering a Medicare Advantage plan

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

can take anywhere from 90 – 180 days. This delay causes access challenges for beneficiaries especially for those with no transportation and HMO plans who reside in assisted and independent living facilities with a non-credentialed provider onsite. An additional issue with these payers' process is they do not retrospect the effective date of the contract back to the effective date or even the date the application was submitted. So, the beneficiary is forced to wait until the credentialing/contracting process has been completed up to 180 days to access care referred to by their physician. As a comparison, the enrollment process for a Medicare private practice group allows for a retrospective effective date within parameters and typically takes 30 – 45 days. We request CMS to direct MAOs to process credentialing and contracting applications for Medicare providers timelier and to make the effective dates retroactive in line with CMS's established process. As the number of Medicare beneficiaries enrolled in Medicare Advantage plans continues to grow quickly due to the additional healthcare benefits and financial flexibility; beneficiaries have decreased access due to these credentialing timelines, significantly reduced reimbursement compared to Medicare allowable rates, and increased administrative burden. We believe CMS needs to standardize MAO processes and monitor strategies more closely to ensure beneficiaries are receiving timely care and providers are not burdened by unnecessary administrative work when their time is best spent treating beneficiaries.

Review of Administrative Burden to Providers

NARA recommends that CMS review the administrative burden of providers related to the multiple audits and other regulations. Some of the top administrative burdens SNFs and their therapy providers incur that cause providers to focus on paperwork over patient care include but are not limited to:

- 5-Claim Targeted Probe and Educate (TPE)
- Supplemental Medical Review Contract (SMRC) Audits
- RAC Audits
- Medicaid exception reviews
- Contact billing denials from Medicare Advantage plans for CPT codes that no longer require the 59 modifiers
- Managing discrepancies between billed amounts and received payments – some members have reported delays from MACs in updating Physician Fee Schedule from March update
- Discrepancies in reviewer interpretations of documentation requirements
- Credentialing/contracting with Managed Advantage Organizations

Commented [ES25]: This list seems to be specific to SNF burden rather than therapy entities. Should it be reworded?

Commented [CS26R25]: I reworded but open to additional recommendations

Commented [SM27R25]: Instead of a list should we just say the top administrative burdens are

Commented [ES28R25]: I took a stab at rewording. However, agree that a list of 2 is not really a list. 😉

Commented [CS29R25]: I have reached out to Rachel Lux to see if she has any input on administrative burden other than the 2 items listed.

Conclusion

Throughout our comments NARA has noted some of the proposals that would not be necessary if upstream providers had a requirement to share information and the removal of information that we find important to patient care for skilled nursing and long-term care facilities. We hope CMS will take this into careful consideration when finalizing proposals to reimbursement or regulations that increase the administrative burden. Providers are struggling to maintain

operations and care for their patients and protect the health, safety, and well-being of staff even while reimbursement is continuously 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 - 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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President
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