

June 18, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-1718-P
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

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 2020 (CMS-1718-P)

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments in response to the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNF), Quality Reporting Program (QRP), and Value-Based Purchasing (VBP) Program proposed rule for Fiscal Year (FY) 2020. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA recognizes that the world of payment reform is dynamic, and to successfully create an alternative payment methodology for SNFs, all facets of payment reform must be considered. This includes quality measurement, value-based purchasing, and quality reporting; the

development of new payment models, such as bundled payment arrangements and accountable care organizations; and the eventual adoption of a unified post-acute care payment system. APTA appreciates CMS's efforts to ensure that the case-mix components under the proposed payment model accurately address costs associated with individual resident care based on an individual's specific needs and characteristics.

APTA also appreciates CMS's efforts to address the increase in the provision of therapy services to Medicare beneficiaries that is predicated on financial considerations rather than patient needs. As CMS moves forward in the process of implementing the Patient-Driven Payment Model (PDPM), we encourage the agency to continue to engage with stakeholders in a transparent and meaningful manner. Soliciting input and engaging in meaningful dialogue with stakeholders, including APTA, will aid CMS in its efforts to effectuate the PDPM. We respectfully request that you consider our more detailed comments and recommendations provided below.

Issues Relating to PDPM Implementation

Group Therapy Definition

APTA appreciates CMS's proposal to modify the definition of group therapy in the SNF. We agree with CMS's assertion that "therapists have the clinical judgment to determine whether groups of different sizes would clinically benefit their patients, which they should be able to demonstrate with adequate documentation." ***APTA supports CMS's proposal to revise the definition of group therapy to achieve greater alignment with group therapy as defined in inpatient rehabilitation facilities (IRFs), specifically modifying the definition of group therapy in SNFs to read: "2 to 6 residents who are performing the same or similar therapy activities." Revising the definition of group therapy in SNFs to mirror that of IRFs would promote consistency across Part A settings.*** Additionally, modifying the definition of group therapy would allow physical therapists and other therapy professionals to exert greater authority in addressing the specific needs of residents while ensuring that residents continue to receive the majority of therapy services on an individual basis. ***We also recommend that CMS adopt a safeguard to ensure that when SNFs deliver group therapy to 6 residents under the new definition, it is clinically appropriate and not for the purposes of financial gain. At a minimum, we encourage CMS to instruct its audit contractors to be mindful of this new group therapy definition and pay close attention to the size of groups when the medical record indicates group therapy was delivered. APTA also encourages CMS to reinforce in final rulemaking the importance of deferring to the professional judgment of the therapist to decide which combination of each mode of therapy is most appropriate to treat each patient as medically necessary in accordance with Medicare coverage guidelines for skilled therapy.***

APTA supports CMS's efforts to afford greater flexibility to physical therapists and other therapy professionals to develop an individualized care plan tailored to the needs of each patient and deferring to the clinical judgment of the therapist to decide which combination of each mode of therapy is most appropriate to treat the patient, as medically necessary in accordance with Medicare coverage guidelines for skilled therapy. ***We recommend, however, that CMS limit the burdensome documentation requirements for providing group therapy.*** It is unreasonable to require that SNFs include in the patient's plan of care "an explicit justification for the use of group, rather than individual or concurrent" therapy and that the description include, but not be

limited to, “the specific benefits to that particular patient of including the documented type and amount of group therapy.” While the therapist may anticipate that some patient populations will benefit from group therapy, it may not be apparent at the start of an individual patient’s care. Moreover, there may be residents who are experiencing social isolation and for whom group therapy may be appropriate, but which is not fully recognized at the time the plan of care is being developed. ***Accordingly, if the justification for group therapy is not documented in the plan of care, APTA recommends that CMS allow therapists to justify and plan for group therapy in the progress report and other documentation with an explanation regarding why group therapy was not anticipated at the beginning of care.*** Such modification to the documentation requirements would promote the delivery of group therapy at the appropriate time during the patient’s SNF stay.

Training of Students in SNFs

A positive clinical education experience in the SNF setting provides an opportunity for students to develop the necessary foundation for proficient practice in this and other post-acute settings following graduation. The SNF setting offers a unique opportunity for students to experience working with a diverse population and address the complexities of care in the post-acute setting as a member of an interdisciplinary team. These students gain enhanced problem-solving skills by being engaged in activities that help residents return to their previous level of function or living arrangement or achieve an optimal level of functional performance within the constraints of their illness, injury, or condition.

APTA applauds CMS’s efforts to ensure that the majority of care received by residents is comprised of individual therapy during the SNF stay and supports setting a limit on group and concurrent therapy. We have concerns, however, that maintaining compliance with the 25% combined limitation of discipline-specific concurrent (and group) minutes could result in the supervising therapist/assistant being unwilling to train therapy students because doing so would be inefficient. Moreover, as discussed in more detail below, the unknown nature of potential penalties for exceeding the 25% threshold could lead some SNFs to avoid the risk and reduce the number of students they accept. ***This could result in a shortage of therapy students trained in a SNF setting, translating into a shortage of physical therapists working in the SNF setting long-term, which would decrease access to necessary care for Medicare beneficiaries and the overall quality of care in SNF settings.*** In fact, we are already beginning to hear from our members that SNFs are refusing to train physical therapist and physical therapist assistant students beginning in October due to changes in the SNF payment model.

Under the current policy for Medicare Part A, therapy student minutes may be coded as individual therapy only when only one resident is being treated by the therapy student and the supervising therapist/assistant is not treating or supervising other individuals and he/she is able to immediately intervene/assist the student as needed. As such, students’ minutes are often counted as concurrent therapy when the clinical instructor is also treating a resident. APTA recognizes that SNFs are not required to code student minutes as concurrent. However, treating patients concurrently increases efficiency and can offer a richer, more meaningful experience for the therapy student.

Under the Resource Utilization Groups classification system, where therapy minutes were a determinant of payment, it may have been more appropriate to require that the time the therapy student spends with a patient be billed as if it were the supervising therapist alone providing that therapy. However, as therapy minutes no longer influence reimbursement, the implementation of PDPM somewhat negates the need for such policy. ***Therefore, we encourage CMS to consider how it might revise its policies regarding therapy students.***

For example, therapy could be coded as “individual therapy” by both the therapy student and the supervising therapist/assistant in those instances when therapy students do not require line-of-sight supervision. As such, when therapy students who do not require line-of-sight supervision treat Medicare Part A residents, the supervising therapist/assistant also should be able to treat or supervise other individuals while ensuring he/she is immediately available to intervene/assist the student as needed. Concurrent therapy would continue to be coded as such when the therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line-of-sight of the therapist/assistant or student providing their therapy. Alternatively, APTA recommends that CMS develop a policy that differentiates between therapy students, therapists, and therapist assistants delivering services in the SNF setting, wherein, in instances when therapy students are involved in delivering concurrent or group therapy, CMS could allow for the allocation of group or concurrent therapy minutes when such services are furnished by the student.

As previously stated, we have legitimate concern that the group and concurrent therapy threshold may limit the willingness of SNFs to train students to treat geriatric patients while also significantly diminishing the educational experience by which students are learning how to independently interact and treat older adults. This also would be extremely detrimental from a labor force perspective at a time when resident acuity is increasing, and the United States is facing a critical shortage of geriatric-focused health professionals. APTA encourages CMS to take these concerns and our recommendations into consideration as it drafts the FY 2020 SNF PPS final rule.

Non-fatal Warning Edit

APTA appreciates that in the FY 2019 SNF PPS final rule, CMS finalized its proposal to implement a non-fatal warning edit on the validation report upon submission when the amount of group and concurrent therapy exceeds 25% within a given therapy discipline, which would alert the provider that the therapy provided to that resident exceeded the threshold. ***APTA has concerns that a non-fatal warning edit is insufficient to curb inappropriate excessive use of group and/or concurrent therapy upon PDPM implementation. Therefore, APTA requests that CMS discuss in final rulemaking whether it intends to implement a penalty in future years for providers that exceed the threshold limit and potential penalties under consideration.***

Updating ICD-10 Code Mappings and Lists

APTA supports CMS’s proposal to make nonsubstantive changes to the ICD-10 codes included on the code mappings and lists under PDPM through a subregulatory process. To ensure that stakeholders are aware of the ongoing revisions, we encourage CMS to include a statement on its PDPM webpage with the date of the change, clarifying the changes it has

made to the code mappings and lists. Additionally, we recommend that CMS send a monthly or quarterly newsletter announcing any changes made.

Revisions to Regulation Text

APTA supports CMS’s proposal to revise 42 CFR §413.343(b) to state that the assessment schedule must include performance of an initial patient assessment no later than the eighth day of posthospital SNF care. APTA also supports CMS’s proposals to modify the regulation text to clarify that the 5-day assessment is an initial patient assessment.

SNF QRP

APTA supports CMS’s goal of improving the quality of health care for Medicare beneficiaries. The physical therapy profession is committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice.

Proposed Transfer of Health Information to the Provider and Patient PAC Measures

APTA supports CMS’s proposal to adopt the Transfer of Health Information to the Provider–PAC quality measure and Transfer of Health Information to the Patient–PAC quality measure. We agree that transfer of a medication list between providers is necessary for medication reconciliation interventions, which have been shown to be a cost-effective way to avoid adverse drug events by reducing errors, especially when medications are reviewed by a pharmacist using electronic medical records. However, we have concerns that the proposed Transfer of Health Information to the Provider-PAC quality measure denominator fails to recognize the importance of transmitting the medication list to other providers, beyond those included in the current definition of “subsequent provider.”¹

It is important to note that outpatient physical therapy is often provided following a patient’s discharge from the SNF, and in many instances, the physical therapist in private practice serves as the first provider after discharge. Physical therapists performing medication management in accordance with their state practice act is a critical element of a physical therapist’s patient evaluation. It is imperative that the physical therapist is aware of the risk of potential adverse events that may occur due to current, changed, and/or new medications. Addressing medications in a drug regimen review and medication reconciliation should be an integral part of practice to help ensure that appropriate patient care is delivered, and optimal clinical outcomes are obtained. APTA has previously issued a statement on the role of physical therapists in medication management as related to homecare. As stated by APTA, “It is within the scope of the physical therapist to perform a patient screen in which medication issues are assessed even if the physical therapist does not perform the specific care needed to address the medication issue. The physical therapist is competent and qualified to serve as case manager and facilitate coordination of care with physicians and nurses.”²

¹ The measure denominator is the number of SNF resident stays, ending in discharge to a “subsequent provider,” which is defined as a short-term general acute-care hospital, SNF, intermediate care (intellectual and developmental disabilities providers), home under care of an organized home health service organization or hospice, hospice in an institutional facility, IRF, long-term care hospital, Medicaid nursing facility, inpatient psychiatric facility, or critical access hospital.

²[American Physical Therapy Association. Official Statement: The Role of Physical Therapists in Medication Management. 2010.](#)

Moreover, physical therapists have the professional capability and ability to refer to others in the health care system for identified or possible needs that are beyond the scope of physical therapist practice. Therefore, although physical therapists are not acknowledged as a “subsequent provider” under the measure definition, *APTA requests that CMS monitor whether there may be a need to include physical therapists as a “subsequent provider” under the Proposed Transfer of Health Information to the Provider-PAC quality measure denominator in the future, given the frequency under which physical therapists in private practice receive the medication list following discharge.*

Proposed Update to the Discharge to Community – PAC SNF QRP Measure

APTA supports CMS’s proposal to exclude baseline nursing facility (NF) residents from the Discharge to Community–PAC SNF QRP measure beginning with the FY 2020 SNF QRP, with baseline NF residents defined as SNF residents who had a long-term NF stay in the 180 days preceding their hospitalization and SNF stay, with no intervening community discharge between the NF stay and hospitalization.

SNF QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs) under Consideration for Future Years: Request for Information

CMS seeks input on the importance, relevance, appropriateness, and applicability of each of the measures, SPADEs, and concepts under consideration listed in Table 13 for future years in the SNF QRP.

Assessment-Based Quality Measures and Measure Concepts

- Functional maintenance outcomes
- Opioid use and frequency
- Exchange of electronic health information and interoperability

Claims-Based

- Healthcare-Associated Infections in SNF – claims-based

SPADEs

- Cognitive complexity, such as executive function and memory
- Dementia
- Bladder and bowel incontinence including appliance use and episodes of incontinence
- Care preferences, advance care directives, and goals of care
- Caregiver Status
- Veteran Status
- Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

APTA supports the inclusion of the proposed SPADEs in future years of the SNF QRP. Each of these categories represents element(s) that will provide a fuller picture of the patients that physical therapists and physical therapist assistants serve in the SNF setting, and therefore could

https://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Coding_and_Billing/Home_Health/Comments/Statement_MedicationManagement_102610.pdf

be used for a variety of purposes, including informing payment and creating and risk adjusting quality measures.

Proposed Standardized Patient Assessment Data Reporting Beginning With the FY 2022 SNF QRP - Proposed Standardized Patient Assessment Data by Category

Cognitive function and mental status data

While APTA supports the inclusion of standardized items such as the Brief Interview for Mental Status (BIMS) and Confusion Assessment Method (CAM) to collect data regarding cognition and mental status, these assessments lack the appropriate sensitivity for identifying mild-moderate cognitive impairments that may impact performance of activities of daily living (ADLs). We appreciate, however, that CMS recognizes that these assessments are imperfect and are seeking data to support the identification of better cognitive assessments. We also encourage CMS to consider the inclusion of other elements in future years to increase the sensitivity of these assessments. *Further, while we would support CMS's efforts to use these data elements as risk adjusters for quality measures, we recommend that CMS continue to monitor these risk adjusters in the future and make appropriate adjustments to the risk adjustment methodology as warranted.* For instance, if there is a high use of cancer services in this patient population and feel that question should be explored further to stratify that population more appropriately, we would support the expansion of the category. Finally, APTA supports inclusion of the Patient Health Questionnaire 2 to 9. We appreciate CMS's proposal to include these data elements within the definition of standardized patient assessment data under the category of cognitive function and mental status.

Special services, treatments, and interventions

APTA supports the collection of data on special services, treatments, and interventions.

Collecting this data will help to better inform CMS and SNF providers on the severity and needs of patients in this setting in the future. Patients who receive services such as dialysis, ongoing oncology care, and nutritional support are often more complex in their clinical presentation. APTA does not have any additional suggestions for data elements in this category.

Medical condition and comorbidity data

APTA supports the inclusion of pain interference data elements. Pain interference is an important dimension in assessing the impact of pain. Including pain interference questions on sleep, therapy, and day to day activities will provide a more accurate picture of how pain impacts a patient's ability to function throughout the day. Such information also will support providers in their efforts to deliver pain treatment and management services, including pharmacologic and non-pharmacological interventions, in a more effective manner.

Impairments

APTA supports the collection of information on hearing and vision in the assessment. Vision and hearing impairments can impact multiple aspects of care and the quality of life of patients across settings.

Social determinants of health

APTA supports CMS's proposal to adopt the following seven data elements as SPADEs under the proposed Social Determinants of Health category: race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation.

Proposed Data Reporting on Residents for the SNF Quality Reporting Program Beginning With the FY 2022 SNF QRP

APTA supports the shift to quality reporting on all payer data in this setting. This is consistent with other quality programs (such as the Merit-based Incentive Payment System) and will allow multiple payers to use the same quality measure information in the future. Additionally, reporting all payer data gives consumers a fuller picture of the quality of care in a given setting.

Proposed Policies Regarding Public Display of Measure Data for the SNF QRP

APTA supports the public display of data for the Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care Skilled Nursing Facility Quality Reporting Program measure beginning calendar year 2020 or as soon as technically feasible.

SNF VBP

CMS adopted the SNF 30-Day Potentially Preventable Readmission measure (SNFPPR) as the SNF all-condition risk-adjusted potentially preventable hospital readmission measure for the SNF VBP Program to meet the requirements in section 1888(g)(2) of the Social Security Act. The SNFPPR is one of two potentially preventable readmission measures specified for use in the SNF setting. The SNFPPR is specified for use for the SNF VBP Program and a second measure, the Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program, is specified for use in the SNF QRP. While these two measures are aligned in terms of exclusion criteria and risk adjustment approach, they differ in their readmission windows. The SNFPPR utilizes a 30-day post-hospital discharge readmission window, while the SNF QRP potentially preventable readmission measure utilizes a 30-day post-SNF discharge readmission window. To minimize confusion surrounding these two different measures, CMS proposes to change the name of the SNFPPR to Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge.

APTA supports CMS's proposal to revise the SNFPPR measure name to "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge." We believe the renaming of this measure provides a more accurate description of the measure.

Public Reporting on Nursing Home Compare

APTA supports CMS's Nursing Home Compare proposal discussed in the FY 2020 proposed rule.

Additional Recommendations

To aid SNFs in their coding efforts under PDPM, APTA encourages CMS to immediately move forward with finalizing the Revisions to Requirements for Discharge Planning for Hospitals,

Critical Access Hospitals, and Home Health Agencies (CMS-3317-P) proposed rule, posted on November 3, 2015. It is imperative that hospitals recognize and understand the importance of transmitting medical records in a timely manner, and CMS holds hospitals responsible for communicating all medically necessary information that is required for SNFs to appropriately and accurately complete patient assessments. The ease of electronic submission of this information is critical in discharge planning and transitions in care. APTA is committed to the adoption of electronic health records, implementation and enforcement of privacy and security protections, and utilization of electronic health information to foster health information exchange where it is not currently taking place. We also support coordinated patient-centered quality care through utilization of electronic health information and look forward to being an active participant in the evolution of an interconnected electronic health system. To that end, the implementation of PDPM strongly reinforces the need for CMS to increase its efforts to advance interoperability between providers.

Conclusion

We thank CMS for the opportunity to comment on the FY 2020 SNF PPS, VBP, and QRP proposed rule. APTA is eager to work with the agency in implementing the new payment model in a manner that safeguards Medicare beneficiaries' access to medically necessary physical therapy services within the SNF setting. If you have any questions regarding our comments, please contact Kara Gainer, Director of Regulatory Affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,



Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

SLD: krg