

June 27, 2011

Donald Berwick, M.D., M.P.P
CMS Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1351-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically

RE: File Code CMS-1351-P Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Disclosures of Ownership and Additional Disclosable Parties Information Proposed Rule (Fiscal Year 2012)

Dear Dr. Berwick:

On behalf of our 78,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is submitting comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding the Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities for FY 2012 published in the *Federal Register* on May 6, 2011. As you are aware, physical therapy is an essential service furnished to Medicare beneficiaries in skilled nursing facilities, and therefore we are very concerned about the impact that changes included in this proposed rule will have on the provision of physical therapy services and the patients that need these services in the skilled nursing facility (SNF) setting.

Over the past year, CMS has finalized significant changes in the policies that govern the SNF setting including the transition from Resource Utilization Group (RUG) 53 and Minimum Data Set (MDS) 2.0 to RUG-IV and MDS 3.0. As a result, physical therapists and other clinicians who practice in these settings have had to make considerable adjustments to their documentation and compliance plans. The task to ensure that clinicians in these settings are fully indoctrinated on the new policies and understand how to comply has been a collective effort between CMS, industry leaders and professional organizations such as APTA. The growing pains of these transitions are still on-going, and APTA believes that the true effect of these changes has not been fully realized due to the need to collect and analyze additional data.

In this proposed rule, CMS has again proposed substantial revisions to the SNF PPS that we believe will significantly alter the manner in which SNFs currently operate and therefore require substantial resources to ensure that clinicians such as physical therapists are aware and ready to comply with the new requirements. While APTA stands ready to assist the Agency in ensuring

the SNF PPS is crafted in a manner that provides quality care to Medicare beneficiaries and mitigates fraudulent and abusive behaviors, we believe that several of the proposed policies are premature and should be delayed and considerably revised before the final rule is promulgated.

With this in mind, we strongly urge CMS to consider the following recommendations articulated below. Our comments address five issue areas:

- I. Collection and further analysis of data before payment cuts and parity adjustments are implemented
- II. Justification and alternate proposals for the provision of group therapy in the SNF setting
- III. Support for the adoption of proposals to revise SNF student supervision policies
- IV. Modifications to proposed therapy assessments (End-of-Therapy OMRA (EOT-OMRA), End-of-Therapy Resumption OMRA (EOT-R OMRA), and Change-of-Therapy OMRA (COT-OMRA)); and
- V. Considerations for on-going initiatives under the Affordable Care Act (ACA)

Payment Updates and Parity Adjustments

In the proposed rule, CMS offers two options for recalibrating the case-mix classification system in order to refine payments for SNFs in fiscal year (FY) 2012. In the first option, CMS states that the Agency applied an upward adjustment of 61 percent to the RUG-IV nursing case-mix indexes (CMI) to achieve aggregate payment parity between RUG-53 and RUG-IV models based on analysis using final 2009 claims data. As part of this analysis, CMS has indicated that it will make adjustments as more data becomes available.

In looking at real first quarter data for FY 2011, CMS states that the data shows that there are great variances in actual RUG-IV utilization versus projections made using FY 2009 claims data. Specifically, CMS states that the number of patients grouped in the highest paying RUG levels were much greater than expected. The actual claims data also showed a substantial increase in the utilization of individual and group therapy which the Agency believes also may account for patients being placed in the highest RUG categories.

CMS also notes that based upon its initial findings from RUG-IV claims data, the FY 2011 parity adjustment may have had the unintended consequence of increasing overall SNF PPS payment levels. Thus, an additional recalibration may be warranted in the FY 2012 final rule to assure budget neutrality.

Therefore, CMS has determined that the adjustment, which produced the 61 percent increase, would need to be reduced by 22.5 percent to achieve budget neutrality if applied equally to all nursing CMIs. Based on this rationale, CMS is proposing the option to apply the adjustment only to the nursing CMIs for the RUG-IV therapy groups and not to the nursing CMIs for RUG-IV non-therapy groups. Using this recalibration method, CMS estimates that the nursing CMIs of the RUG-IV therapy groups would be updated by 19.81 percent. This would result in an overall 11.3 percent reduction in SNF payments for FY 2012.

Under the second option, CMS is considering not recalibrating the CMI's for FY 2012 and applying the standard update to the FY 2011 payment rates. CMS concedes that the realized overpayments may represent "temporary aberrance(s)" as a result of limited data availability. CMS notes that the availability of additional data may give more insight into utilization patterns allowing the Agency to make more accurate recalibration adjustments to the CMI's.

APTA urges CMS to adopt the latter approach in the FY 2012 final rule. We believe that making major recalibration adjustments that result in large decreases in payment to SNFs is premature and should be more carefully analyzed and examined with more data to ensure that these increased utilization patterns are real and are not aberrancies due to transition issues from RUG-53 to RUG-IV. **In addition, we recommend that CMS phase-in any large cuts such as the projected 11.3 percent cut over a 3 to 4 year period as has been conducted in the past under other prospective payment systems, notably the home health PPS.**

Group Therapy

In the proposed rule CMS states that based on data retrieved after the implementation of the FY 2010 final rule that allocated concurrent therapy time to reflect resource utilization, CMS found there was a decrease in concurrent therapy, but a significant increase in group therapy services, which were not subject to the allocation. Given this increase, CMS is concerned that the current method for reporting group therapy on the MDS 3.0 creates an inappropriate payment incentive to perform the less intensive group therapy in place of individual therapy, because the current method does not require allocation among patients.

CMS states that the optimal number of patients for group therapy is four, and CMS believes that when a therapist treats four patients in an hour, it does not cost the SNF four times the amount to provide those services. The therapist would still receive one hour's salary for the hour of therapy provided. Therefore, CMS proposes to allocate group therapy minutes among the four group therapy participants stating that this approach "*best captures the resource utilization associated with providing a maximally beneficial group therapy intervention.*"

In addition, consistent with the current policy, CMS points out that the supervising therapist may not be supervising any individuals other than the four in group therapy at the time of the therapy session. CMS believes group therapy can play an important role in SNF patient care. However, because group therapy may not be appropriate for all patients or all conditions, SNFs are expected to include an explicit justification for the use of group therapy in the plan of care to verify that group therapy is medically necessary and appropriate to the needs of the patient.

APTA has serious concerns about the adoption of this policy and strongly urges CMS to:

- 1) Rescind its proposal to narrowly define group therapy as four patients at all times. We strongly believe that effective group therapy sessions can be achieved with 2 to 4 patients.**

- 2) **Revise its proposal regarding the allocation of minutes. If group therapy sessions are comprised of 2 or 3 patients. The minutes should be allocated accordingly and not arbitrarily divided by 4.**
- 3) **Re-examine the 25 percent limitation on group therapy. We contend that if minutes are allocated, the 25 percent limitation should be eliminated or significantly revised.**

We contend that CMS has made these assumptions regarding group therapy too hastily based on flawed information from the STRIVE project and limited data from the first quarter after the implementation of RUG-IV and MDS 3.0. While we share CMS' vigor to ensure that group therapy is furnished in a manner that is clinically appropriate and mitigates programmatic abuse, we strongly believe that policies such as these should be carefully crafted as to avoid unduly penalizing of all SNF providers for a small percentage of offenders.

APTA asserts that when clinically indicated in the plan of care, group therapy can serve as an appropriate mode in which to deliver therapy to a particular patient. The patient benefits of group therapy are numerous. They include functional improvements, greater psychological and social awareness, and educational opportunities. In addition, group therapy promotes social interaction and motivation among SNF patients.

We are greatly concerned with the intimation that group therapy is a lesser mode of therapy and contend that group therapy can be as intensive as one one-on-one therapy. While in group therapy, the patient is receiving multiple levels of stimulation from interaction with other patients within the group as well as the instruction and guidance of the therapist. In addition, the patient must learn to focus his/her attention and control his/her physical movements while facing a demanding set of objectives.

For example, group therapy is particularly beneficial for patients with strokes and other neurological conditions and patients who suffer from severe orthopedic conditions, such as rheumatoid arthritis, osteoporosis with previous fragility fractures, and bone cancer. Group therapy also requires a high level of skill and work on the part of the therapist as he or she is faced with managing the multiple issues associated with the group dynamic as well as the forethought and judgment to discern how and when to incorporate group therapy into the patient's plan of care.

To further illustrate our points regarding the benefits and medical necessity of group therapy, consider the following clinical scenario:

Patient A had a stroke two weeks ago and has been admitted to the SNF setting. In the plan of care, the physical therapist, after a comprehensive evaluation of the patient, has determined that this patient would benefit from group therapy. Therefore, the patient begins to participate in group physical therapy as part of their care to improve function and aerobic capacity. Group therapy provides the opportunity for the patient to perform therapeutic exercises to help improve aerobic capacity, balance, coordination, flexibility, neuromotor development, and strength. The group setting further provides the patient an opportunity to engage in psychosocial activities that

both motivate and provide an environment for shared empathy. The group intervention meets Medicare's definition of skilled therapy. The patient benefits as the therapist works with the patient on a periodic individualized basis and in a group setting. After discharge, the patient is placed in a home and community-based setting and the lessons and skills learned during group therapy, in addition to their individualized care, help to effectively and safely transition the patient to this social setting.

We also contend that there is no clinical basis for defining the group as four patients. Group therapy has been shown to be effective in the rehabilitation of patients. However, there is no evidence that indicates the value or effectiveness of the number of participants in a group. APTA strongly contends that there are instances in which 2 or 3 patients being treated in a group therapy session is wholly appropriate and clinically acceptable. For patients who may have balance deficits, cognitive impairments, and multiple co-morbidities, participating in a group of 4 patients may pose serious patient safety risks. Yet, these patients may still benefit from the social interaction as well as multiple levels of stimulation derived from group therapy if treated in a smaller group consisting of 2 patients.

To illustrate this point, please consider the following clinical scenarios:

The physical therapist is working with 4 patients on dynamic balance exercises in a sitting position on mat tables. Each patient has a different diagnosis: Patient A has a left sided stroke (CVA) with right hemiparesis and apraxia, Patient B is status-post and intensive care unit (ICU) stay following acute respiratory distress syndrome (ARDS), Patient C suffered a brain injury from a fall and subsequently has new onset cognitive impairment, and Patient D is in an exacerbation of Multiple Sclerosis. Each patient is very different clinically; however all have weak trunk musculature. Each patient requires some level of assistance and supervision. While all of these patients would benefit from group therapy, it would be difficult for the physical therapist to engage and facilitate safe treatment of all of these patients at one time. However, if the group was reduced to two patients, it would be much more likely that the patient could still participate in and benefit from group therapy without risk of patient safety.

Because each patient may have differing co-morbidities in the group, some patients may require more interaction with and clinical decision making of the physical therapist. In the example above, the patient post ICU stay may require more intensive monitoring of blood pressure, pulse, oxygen saturation, and respiratory rate throughout the group therapy session in order to determine if he/she may continue with the group therapy program or if the exercise requires modification. This requires more of the therapist's time. Similarly, the patient with apraxia may require more tactile cueing to facilitate motor planning in order to perform the balance/trunk muscle re-education activities properly and safely, thereby taking more of the therapist's time.

In the alternative, patients with similar diagnoses, such as patients status post total hip replacement may be well suited to having 4 patients in a group that is engaging in a pre-defined lower extremity strengthening exercise program, (if after evaluation their co-morbidities are determined to not pose a patient safety risk). In conclusion, group therapy (as with all therapy)

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should be based on the needs of the patient depending on their condition and complexity and not some arbitrary policy that has no clinical or evidence basis.

Therefore, we strongly urge CMS to rescind its definition of group therapy and to continue to define it as follows: the treatment of 2 to 4 patients who are performing the same or similar activities. This definition provides the flexibility to design group therapy programs that are safe, effective and clinically appropriate for patients with a myriad of conditions and co-morbidities.

Additionally, CMS should revise its proposal to allocate minutes by dividing the total time of the therapy session by the actual number of patients who are involved in the group therapy program (2, 3 or 4). We recognize that this may require extensive technical resources and coordination on the part of CMS and facilities, but we strongly believe that allocating by using the actual number of patients in the group is necessary to ensure accuracy of recorded therapy minutes on the MDS.

Lastly, the proposed rule states that the 25 percent cap on group therapy minutes will remain in effect as CMS continues to believe that group therapy should serve only as an adjunct to individual therapy. While we agree that individual therapy is an optimal mode of therapy and should compose the majority of the minutes of therapy provided to the patient in the SNF setting, as stated earlier, APTA also believes that group therapy is an effective and important mode of therapy that should not be viewed as a “less intense” mode of therapy. Therefore, we believe that the enforcement of the 25 percent limitation in concert with the allocation of therapy minutes is redundant and unnecessary.

As evidenced by the initial data collected and discussed in the proposed rule, CMS saw a sharp decline in the utilization of concurrent therapy after the policy to allocate concurrent therapy minutes was implemented on October 1, 2010. If the data is indeed accurate, CMS should see a decrease in the use of group therapy once it finalizes the policy to allocate minutes as well. Therefore, we strongly urge the Agency to lift the 25 percent limitation and examine data after the implementation of the policy to allocate group therapy minutes to assess if a limitation is necessary and if so, what is the appropriate percentage.

In the proposed rule, CMS discusses its willingness to work with professional organizations such as APTA to capture a more accurate picture of group therapy and the types of patients that benefit from this type of therapy. We believe the information we have provided within these comments is a good start to that dialogue, but we would also request CMS convene a technical expert panel to examine this issue further. APTA has several member experts that could serve on this panel to aid CMS in this endeavor.

SNF Student Supervision Policy

In the FY 1999 SNF PPS final rule, CMS mandated that a therapy student in the SNF setting must be in the “line-of-sight” of the professional therapist while the standards for other inpatient

settings are silent on the issue of therapy student supervision. Because CMS considered it inequitable for SNFs to be subject to a more restrictive set of standards for student supervision than other inpatient settings, CMS proposes to eliminate the line-of-sight supervision requirement. Instead, each SNF will be able to determine for itself the appropriate manner of supervision for therapy students, consistent with applicable State and local laws and practice standards.

APTA commends CMS for the inclusion of this proposal as we strongly believe that it should be within the judgment of the therapist to decide the appropriate level of supervision for the therapy student. The SNF setting serves a critical role in the clinical education of therapy students and therefore should have the freedom to create an environment that encourages and fosters the relationship between SNFs and therapy educational programs.

Therefore, we recommend that CMS in tandem with the promulgation of the final rule revise the Resident Assessment Instrument (RAI) manual to clarify the following:

- 1. The amount of supervision must be appropriate to the student's level of knowledge, experience, and competence.**
- 2. Students who have been approved by the supervising therapist or assistant to practice independently in selected patient/client situations can perform those selected patient/client services specified by the supervising therapist/assistant.**
- 3. The supervising therapist/assistant must be physically present in the facility and immediately available to provide observation, guidance, and feedback as needed when the student is providing services.**
- 4. When the supervising therapist/assistant has cleared the student to perform medically necessary patient/client services and the student provides the appropriate level of services, the services will be counted on the MDS as skilled therapy minutes.**
- 5. The supervising therapist/assistant is required to review and co-sign all students' patient/client documentation for all levels of clinical experience and retains full responsibility for the care of the patient/client.**
- 6. Therapist assistants can provide instruction and supervision to therapy assistant students so long as the therapist assistant is properly supervised by the therapist.**

Therapy Assessments

EOT OMRA and EOT-R OMRA

In the proposed rule, CMS clarifies that SNF providers must complete an EOT-OMRA for a patient classified in the RUG-IV therapy group if the patient goes 3 consecutive days without being furnished any therapy services, regardless of the whether the reason for the discontinuation is planned or unplanned. *“If therapy resumes, the SNF may complete the optional start of therapy (SOT) OMRA, which is used to reclassify the patient into a therapy RUG-IV group at any time point during a resident’s Part A stay SNF stay until completion of the next regularly scheduled PPS assessment.”*

CMS recognizes that this policy has caused some confusion and difficulty for SNF providers who use weekends to make up missed therapy that was not provided during the week or who arrange special therapy schedules around the holidays as it is unclear to these providers as to whether they are considered 5-day or 7-day facilities. To alleviate the confusion, CMS proposes to eliminate the distinction between the 5-day and 7-day facilities for purposes of setting the assessment reference date (ARD) for the EOT OMRA. Therefore, CMS clarifies that an EOT OMRA for a patient classified in a RUG-IV therapy group would be required if that patient goes 3 consecutive calendar days without being furnished any therapy services regardless of the SNF status as a 5-day or 7-day facility.

In addition, CMS acknowledges that there are instances in which the completion of an EOT OMRA and SOT OMRA may not be necessary in cases where therapy services resume at the same mode and intensity as the patient was receiving before the discontinuation of therapy services. In these instances, CMS proposes that when an EOT OMRA has been completed and therapy subsequently resumes, SNFs may complete an EOT-R OMRA, rather than an SOT OMRA, in cases where therapy services have ended for a period of no more than 5 consecutive calendar days, and have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA.

APTA appreciates CMS willingness to modify the SNF discontinuation policy to give more flexibility in situations where SNFs have breaks in care due to holidays, staffing issues, or patient refusal of therapy, but we still believe that further modifications can be made to this proposal to ensure that SNFs and their therapists are not unduly burdened with unnecessary administrative requirements and restrictions.

Therefore, we strongly recommend that CMS make the following modifications to this proposal:

- 1) CMS should make a clear distinction between planned and unplanned breaks in care and if properly documented in the medical documentation, allow SNFs the flexibility of at least 4 days to resume therapy without triggering the requirement to complete the EOT-OMRA.**

- 2) **CMS should clarify in the final rule the distinctions between the EOT-OMRA and EOT-R OMRA. It should not be required that both of these assessments be completed in order to resume therapy. CMS should mandate that in those situations where therapy will resume in less than 5 consecutive calendar days, that only the EOT-R OMRA should be completed and not the EOT OMRA. The completion of both of these assessments is redundant.**
- 3) **CMS should provide detailed information in the final rule regarding the requirements of the EOT-R OMRA and allow stakeholders to provide input before the requirements are finalized in the RAI-manual.**

First, as indicated above, CMS discusses in the proposed rule the distinction between planned and unplanned breaks in care and acknowledges that there may be instances where there are planned breaks in care that do not warrant a significant change in the patient's condition or intensity of therapy services. But, CMS fails to make an exception for these circumstances. **APTA strongly recommends that CMS not subject SNFs who encounter planned breaks in therapy to the same requirements as delineated for unplanned breaks in care. We believe that these two instances are separate and distinct and should be treated as such.**

For example, a patient plan of care indicates that therapy is to be furnished 5 times a week. The patient is typically seen Monday through Friday, but one week an exception is made and the patient is seen by the physical therapist Sunday through Thursday. This was a planned break in the schedule and was agreed upon with the patient. . The patient is then seen Monday through Friday of the following week. In this instance, no therapy is missed and should not necessitate the completion of the EOT-OMRA (or the EOT-R OMRA).

Secondly, throughout the development of the SNF PPS, CMS has indicated that SNFs furnish care to some of the most fragile and clinically complex patients within the Medicare program. CMS should give SNFs the ability to adjust therapy services due to patient refusal, and/or temporary or transient issues. As indicated in the proposal for the EOT-R OMRA, CMS recognizes that in some instances a three day break in care does not affect the mode or intensity of services provided to the patient. Therefore, we contend that 3 consecutive calendar days is not enough time for the SNF to determine whether or not the patient's situation warrants the completion of the EOT-OMRA. We believe that a more equitable and fair period to make this determination would be over 4 days instead of 3 days and we urge CMS to make this modification in the final rule.

In addition, APTA believes that is unnecessary to require the SNF to complete the EOT-OMRA and EOT-R OMRA in those instances where therapy will resume in less than 5 consecutive calendar days.

For example, the patient is being seen by the physical therapist 5 times a week (Monday through Friday). Patient is seen under this schedule without interruption May 23 through June 10. On Monday, June 13, the patient complains of fatigue and an upset stomach from something she ate on Sunday at the nursing home picnic. She declines therapy in the morning. The physical

therapist checks again with her in the afternoon. The patient again declines therapy due to not feeling well. On Tuesday, June 14, the patient is eating well and feels like participating in therapy. She is able to resume her same intensity of therapy session and the treatment session missed on Monday is rescheduled for Saturday June 18.

In this example, the patient has the “right to refuse” treatment if she doesn’t feel up to participating. In many cases (as in this one), it doesn’t indicate a significant change in clinical status has occurred. It is a transient issue. Yet, if the 3 day rule were to be enforced, then an EOT OMRA and an EOT-R-OMRA would have to be completed. APTA asserts that this is overly burdensome, and we strongly urge CMS to correct this situation on the final rule.

COT OMRA

In the proposed rule CMS notes that it has “*found some cases where therapy services recorded on a given PPS assessment did not provide an accurate account of the therapy provided to a given resident outside the observation window used for the most recent assessment.*” CMS states that “*while these changes may pose a significant change in payment, they do not always rise to the level of a significant change in clinical status*”. CMS believes that many of these changes in therapy utilization levels may be unrelated to the patient’s clinical condition and may be caused by staffing constraints or facility practices.

Therefore, CMS proposes that SNFs would be required to complete a Change of Therapy (COT) OMRA, for patients classified into a RUG-IV therapy group, whenever the intensity of therapy (the total reimbursable therapy minutes delivered) changes in a manner that places the patient in a different RUG-IV classification than was assigned on the most recent assessment. The COT observation period would be a rolling 7-day window beginning on the day following the ARD for the most recent scheduled or unscheduled PPS assessment and ending every 7 calendar days thereafter.

APTA strongly objects to this proposal and urges CMS to:

- 1) Withdraw the proposal to implement the COT OMRA and instead conduct further analysis of the situations in which the Agency has raised in this proposed rule to come up with a more appropriate and less burdensome requirement.**
- 2) Allow for grace days either at the beginning or end of the 7-day window for the COT Therapy OMRA to allow SNFs the flexibility to make up therapy that was missed due to patient refusal, transient issues or planned breaks in care.**

We believe this policy is too onerous and unfairly penalizes the SNF when therapy services are missed during the weekdays for justified and well documented reasons.

For example, the patient is being seen by the physical therapist 5 times a week (Monday through Friday). Patient is seen under this schedule without interruption May 23 through June 9. On Friday, June 10, the patient has a scheduled doctor’s appointment at 10:00 am. She declines

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therapy prior to her appointment since he/she has to leave the SNF at 8:30 a.m. and doesn't want to be fatigued. She doesn't return from her appointment until 3:00 pm that afternoon. The physical therapist checks with her in the afternoon to provide therapy.

The patient declines the therapy session because she is tired from her day out and exertion from the doctor's visit. The facility is located in a rural area, more than 30 miles from a metropolitan area. Although the facility tries to locate a physical therapist to come to see the patient on Saturday or Sunday, they are unsuccessful because they are so far away and cannot afford to pay mileage or drive time to attract a therapist to spend 90 minutes driving for a 45 to 60 minute treatment session. The patient is not seen on Saturday or Sunday.

On Monday, June 13, the patient is seen by the regular therapy staff and the minutes of therapy missed on Friday, are divided amongst the treatment schedule for Monday through Friday. However, it will be impossible to make up that 'day' of therapy. In this instance, the SNF would be required to complete the COT OMRA. It would reflect a different RUG-IV classification and payment – not because the number of therapy minutes wasn't achieved – but because five 'days' of therapy in that 7 day period was not met, and that is also a requirement for the upper Rehab RUG levels.

We believe that CMS has not fully assessed the impact of this proposed policy. Essentially, it will require that whenever therapy services are missed during the weekdays – even if for 5 minutes - a COT OMRA must be completed regardless of the clinical reason. We assert that this wholly inappropriate and unfair to SNF providers. Therefore, we strongly urge CMS to withdraw this proposal or at the minimum allow for additional grace days at the beginning or end of the 7-day window.

While we understand CMS' objective to accurately pay for the therapy services provided to the patient, we do not believe the proposed policy of the COT OMRA meets this objective. In the alternative, we request that CMS meet with stakeholders to discuss a more accurate and flexible methodology that will accurately capture changes in reimbursable therapy minutes without penalizing facilities and potentially limiting therapy services to beneficiaries.

On-going Initiatives under the Affordable Care Act

APTA commends CMS for its on-going work to improve quality of care provided to Medicare beneficiaries in the SNF setting and we are committed to proactively advancing this goal. Specifically, we stand ready to serve as a resource to the Agency for the development of the Medicare Skilled Nursing Facility Value-Based Purchasing (SNF VBP) report as required by §3006 of the Affordable Care Act. As stated in the proposed rule, the value-based purchasing program is intended to *“tie payment to performance in such a way as to reduce inappropriate or poorly provided care and identify and reward those who provide effective and efficient patient care”*.

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We have provided previous comments under separate cover regarding the SNF VBS but overall we believe the overarching theme of the report should be to create a program that utilizes quality measures that are evidence-based, risk adjusted and that fully account for the full spectrum of services, including nursing and therapy services, delivered to patients in the SNF setting.

Secondly, we strongly support the establishment of required disclosures of ownership and additional disclosable parties information under § 6101 of the Affordable Care Act. This provision was enacted to improve transparency of information in all Medicare SNFs and Medicaid nursing facilities. Specifically, facilities will be required to make available on request information on ownership, including a description of the governing body and organizational structure of the relevant Medicare SNF or Medicaid nursing facilities, and information regarding additional disclosable parties. In this proposed rule, CMS seeks to take the disclosure requirement one step further by mandating that Medicare SNFs and Medicaid nursing facilities disclose ownership and other disclosable parties at the time of enrollment and when any change in ownership occurs.

APTA strongly believes that disclosure is an important step in creating a federal health care program that is transparent and provides care with the best interest of the patient as the first and foremost prevailing factor. Physician ownership of physical therapy services has long since been an issue that presents inherent conflicts of interests as well as motivations to refer for medically unnecessary services for financial profit. Although the Agency has failed to specifically address the issue of physician-owned physical therapy services under its disclosure authorities under § 6003 of the Affordable Care Act, we believe that implementing this provision for SNFs is a step in the right direction. Therefore, we recommend that CMS finalize this proposal.

APTA thanks CMS for the opportunity to comment on the Skilled Nursing Prospective Payment System Proposed Rule (FY 2012), and we look forward to working with the agency to craft patient-centered payment policies that reflect quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Regulatory and Payment Counsel, at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,



R. Scott Ward, PT, PhD

President

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