

June 12, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1622-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically

RE: CMS-1622-P; Medicare Program - Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2016

Dear Acting Administrator Slavitt:

On behalf of the 90,000 physical therapist, physical therapist assistant, and students of physical therapy members of the American Physical Therapy Association (APTA), I would like to submit the following comments in response to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Fiscal Year (FY) 2016 proposed rule. Physical therapy is an integral service provided to Medicare beneficiaries in the SNF setting. Physical therapists furnish medically necessary services to patients in the SNF to improve their overall health, function and to optimize their quality of life.

The estimated SNF market basket update to payments for FY 2016 is 1.4 percent after applicable adjustments. We commend CMS for proposing an increase in payment for SNF services in FY 2016. A robust set of resources are needed to treat this critically complex population of patients. Therefore, we wholeheartedly support the finalization of the positive payment update.

While we support the overall proposed policies included in this rulemaking, we respectfully request that you consider the comments and recommendations provided below.

Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP Program)

Section 3006(a) of the Affordable Care Act required the Secretary to develop a plan to implement a value-based purchasing program under the Medicare program for SNFs (as defined in section 1819(a) of the Act) and to submit that plan to Congress. Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) added new subsections to the Social Security Act

(Act) which authorizes establishment of a Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance.

CMS proposes to adopt the Skilled Nursing Facility 30-Day All-Cause Readmission Measure, (SNFRM) (NQF #2510), as the all-cause, all-condition readmission measure that will be used in the SNF VBP Program. This measure assesses the risk standardized rate of all-cause, all-condition, unplanned inpatient hospital readmissions of Medicare fee-for-service (FFS) SNF patients within 30 days of discharge from an admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or psychiatric hospital.

Physical therapists play an integral role in the prevention of acute hospital readmissions as essential members of the health care team facilitating transitions in care for patients. Physical therapists, in conjunction with other of the health care professionals, assist in discharge planning, including the determination of the most appropriate setting for a patient taking into account their medical status, functional status, prognosis and other factors, such as their home environment and family support. The need for coordinated efforts across the continuum of care is imperative in reducing preventable readmissions.

APTA supports the proposed adoption of the Skilled Nursing Facility 30-Day All-Cause Readmission Measure, (SNFRM) (NQF #2510). The Skilled Nursing Facility 30-Day All-Cause Readmission Measure is consistent with other CMS readmission measures in the post-acute care and acute care setting. Reducing acute hospital readmissions for all SNF patient populations will decrease cost, improve patient safety and promote the best possible outcomes for these patients. APTA encourages CMS to add additional measures in the future that will round out the VBP profile including measures that look at resource use and outcomes, including functional outcomes and return to the community following discharge.

APTA also supports a value-based scoring methodology that rewards performance and improvement as both are critical components to ensuring high quality patient care. APTA recommends that the methodology be easy to understand and that CMS provides education to SNFs in the early years to assist them in understanding the various aspects of the VBP methodology. APTA supports public reporting of this, and all other quality measures, and encourages CMS to provide regular feedback, as proposed, with SNFs prior to data publication.

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), enacted on October 6, 2014, requires the implementation of a quality reporting program for SNFs. Beginning with FY 2018, the Act requires SNFs that fail to submit required quality data to CMS under the SNF Quality Reporting Program will have their annual updates reduced by 2 percentage points.

The IMPACT Act also imposes new data reporting requirements for certain post-acute care (PAC) providers, including SNFs. The Act requires that the Secretary specify quality measures and resource use and other measures with respect to certain domains not later than the specified

application date that applies to each measure domain and PAC provider setting. The IMPACT Act requires that post-acute care providers use standardized assessment tools as the data source for quality measures that shall be risk adjusted (as determined appropriate by the Secretary) and endorsed by NQF. These standardized assessment tools need to be incorporated into existing setting specific assessment tools (OASIS, IRF-PAI and MDS).

CMS proposes 3 new quality measures for the FY 2018 SNF QRP and subsequent years, addressing 3 quality domains identified in the IMPACT Act:

- Skin integrity and changes in skin integrity (outcomes measure): Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)
- Incidence of major falls (outcomes measures): Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)
- Functional status, cognitive function, and changes in function and cognitive function (process measure): Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631; under review)

Linking quality measures to payment is a new concept to the SNF setting and poses inherent challenges to the selection and implementation of measures. One of the proposed measures (NQF #2631) is still undergoing review by NQF. Implementation of new measures in any setting may increase the likelihood in which setting specific issues may arise in the application of such measures. These setting specific issues, which may include problems with data collection/ submission, and measurement specific issues such as appropriate risk adjustment methodologies, need to be taken into consideration as new measures are introduced. These measure challenges will be present until there is a uniform data set and payment system in place across PAC settings.

APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice. Furthermore, APTA feels that it is essential that we move towards a core set of functional items to assess patients across the continuum of care. APTA is pleased to see that these measures proposed for SNFs move in that direction in accordance with the IMPACT provisions. However, the APTA does have some concerns about these measures, discussed below; therefore setting specific issues will need to be taken into consideration.

Skin integrity and changes in skin integrity (outcomes measure): Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)

APTA supports this measure. APTA believes that measuring skin integrity and changes in skin integrity is important in the post-acute care setting. This measure has been endorsed by NQF in the SNF short-stay setting, as well as in the LTCH and IRF settings. Although this measure is currently risk adjusted, this methodology is based on data obtained from the data collection tools specific to each PAC setting. As CMS moves toward a standard data set under IMPACT, APTA would advocate for continued ongoing evaluation of the risk adjustment methodology.

Incidence of major falls (outcomes measures): Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)

APTA supports this measure in concept. This measure is endorsed by NQF for long stay nursing residents and does satisfy the requirement of a major falls domain measures under IMPACT, however this measure does not include a risk adjustment methodology as required under IMPACT. APTA recognizes that the IMPACT timeline for implementation of the major falls measure for SNFs, IRFs and LTCHs is October 2016, however, we are concerned that this measure needs to include appropriate risk adjustment methodology.

The other widely used falls with injury measure (NQF #0202), which is currently in use in the acute care setting, employs a risk stratification methodology by nursing unit. The risk stratification utilized in the acute care setting for measure #0202 does allow for the identification of different patient populations, based on nursing unit type, for more accurate reporting of falls with injury in higher risk patient populations. There is a concern that implementing the long stay major falls measure into other PAC settings may result in wide variations in reported falls without taking into account patient acuity or other variables that may impact falls risk. Additionally, using this measure in the home health setting will pose even greater challenges as the setting is not structured like the other PAC settings, with the patients residing in their home without continual monitoring. For these reasons APTA would encourage CMS to continue to work on refining this measure to incorporate a risk stratification or adjustment methodology.

Functional status, cognitive function, and changes in function and cognitive function (process measure): Application of Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631; under review)

APTA supports this measure in concept. APTA believes that measuring function is important in every care setting. APTA is pleased to see this measure being proposed for multiple PAC settings in accordance with the IMPACT requirements. Additionally, we feel that facilities should be monitoring the percentage of complete functional assessments, and we note that this measure does align conceptually with the finalized changes to the home health quality reporting requirements for the submission of OASIS data in an attempt to capture “Quality Assessments Only”.

However, APTA has significant concerns as the proposed rule indicates that CMS intends to use “an application” of this measure for the purposes of the SNF (as well as IRF and LTCH) quality reporting program. While we understand that CMS has latitude in implementing endorsed measures in settings for which measures have not yet received endorsement, we are concerned that this measure, as proposed, is inconsistent with the measure that is still under review by NQF. Specifically, we noticed the following differences in the proposed CARE item set (*in italics*):

Skilled Nursing Facility Quality Reporting Program - Quality Measure Specifications for FY 2016 Notice of Proposed Rule Making	NQF Application (NQF#2631) Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
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Self-Care Items	
<ul style="list-style-type: none"> • Eating • Oral hygiene • Toileting hygiene 	<ul style="list-style-type: none"> • Eating • Oral hygiene • Toileting hygiene • <i>Wash upper body</i>
Mobility Items	
<ul style="list-style-type: none"> • Sit to lying • Lying to sitting on side of bed • Sit to stand • Chair/bed-to-chair transfer • Toilet transfer For patients walking: • Walk 50 feet with two turns • Walk 150 feet For patients who use a wheelchair: • Wheel 50 feet with two turns • Wheel 150 feet 	<ul style="list-style-type: none"> • <i>Roll left and right</i> • Sit to lying • Lying to sitting on side of bed • Sit to stand • Chair/bed-to-chair transfer • Toilet transfer For patients who walk: • <i>Walk 10 feet</i> • Walk 50 feet with two turns • Walk 150 feet For patients who use a wheelchair: • Wheel 50 feet with two turns • Wheel 150 feet
Cognitive Function	
<ul style="list-style-type: none"> • 	<p><i>Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]):</i></p> <ul style="list-style-type: none"> • <i>Acute onset and fluctuating course</i> • <i>Inattention</i> • <i>Disorganized thinking</i> • <i>Altered level of consciousness</i>
Communication: Understanding and Expression	
<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • <i>Expression of ideas and wants</i> • <i>Understanding of verbal content</i>
Bladder Continence	
<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • <i>Bladder Continence</i>

Additionally, as submitted for NQF review, measure #2631 requires the collection of other data not initially required by the CARE demonstration project such as projected goal information. While APTA appreciates the need to easily identify patients/ residents who have a care plan that addresses function, we are worried that a collecting an estimated goal for a single CARE item is a poor proxy for the functional plan of care for patients/ residents as the plan of care typically addresses multiple functional limitations in the PAC settings. Furthermore, as this is a limited item set compared to the full self-care and mobility item set in the PAC CARE demonstration, there is a possibility that the functional issues that are being addressed may not be represented in this measure. Lastly, it is also important to recognize that for many patients the goal of therapy is restorative, however in some instances skilled therapy services may focus on maintenance of a patient’s function. Again, APTA recognizes that as the IMPACT measures are implemented and

as we move to standardized assessment tools across the PAC settings, these measures may need modifications. We are hopeful that CMS will comment on these concerns in the final rule.

Although this measure does address the required domain of functional status it does not capture functional outcome. CMS has in fact proposed functional outcome measures for IRFs in this rulemaking cycle (IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633, under review), IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634, under review), IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635, under review), IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636, under review)), however, none of these measures were included for the LTCH or SNF settings. Additionally, NQF has recently reviewed functional outcome measures for the SNF setting based on items from the CARE tool (CARE: Improvement in Mobility (NQF #2612, under review), and CARE: Improvement in Self-Care (NQF #2613, under review), however, neither of these measures were put forth as measures for consideration during the Measures Application Partnership (MAP) ad hoc measures for the Improving Medicare Post-Acute Care Transformation Act process. APTA encourages CMS to incorporate functional outcome measures in future years in the SNF and other PAC quality reporting program as timely comprehensive functional data will be needed in order to make informed decisions about future payment systems for PAC settings.

APTA recognizes that the overall goal of IMPACT is for PAC providers (HH, IRF, SNF and LTCH) to collect and report standardized and interoperable patient assessment data, quality and resource use measures. We acknowledge that during the initial IMPACT implementation years that there will be a transition period from existing data collection tools to incorporate standardized assessment tools. APTA is concerned about the duplicity in data collection that this measure introduces and the burden of data collection for the providers given the current data collection tools in the PAC settings, specifically MDS 3.0 in the SNF setting. APTA encourages CMS to consider a short transition period to standardize the patient assessment data in order to decrease the issues around duplicity and provider burden in data collection, this includes considering the removal of items from the existing data sets where possible. Additionally, we believe that achieving a standardized and interoperable patient assessment data set as quickly as possible will allow for better cross-setting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT.

During the transition period CMS must consider not only the additional reporting burden to providers as the new standardized data items are implemented, but also the educational burden. Given the differences in the instructions and rating systems of all of the PAC functional assessment items, we strongly encourage CMS to offer standardized education that can be made available to all providers who will be using the new CARE items. This education will need to take place throughout the transition period in order to achieve high a degree of reliability of these items.

Lastly, APTA would like to encourage CMS to continue in ongoing stakeholder engagement in this process as we move toward PAC data standardization; this includes changes that are made through the regulatory process as well as the measures endorsement process through NQF. We

anticipate that the functional measures will evolve over time to include additional CARE self-care and mobility items that are not included in this first functional measure. The inclusion of new items should help to ensure true representation of patient function at the low, as well as the high ends of the spectrum. Additionally, we would encourage CMS and other measure developers to consider functional items such as velocity or gait speed which may provide a more meaningful picture of the quality of mobility performance versus ambulation distance which is a measure of tolerance. APTA and its members appreciate the opportunity to work with CMS during the implementation phase of IMPACT.

Staffing Data Collection

CMS proposes to require long-term care facilities such as SNFs and nursing homes that participate in Medicare and Medicaid to submit staffing information based on payroll data. The proposed rule requires facilities to electronically submit to CMS complete and accurate direct care staffing information, including information on agency and contract staff, beginning July 1, 2016.

SNFs would be required to provide information on the category of work a certified employee performs, hours of care provided broken into the categories of certified employees per resident per day, resident case-mix and census data, and employee turnover and tenure. Certified employee includes contract and agency staff in addition to direct employees and SNFs must identify each certified employee as contract, agency, or direct employee. SNFs also would be required to report the each individual's start and end dates.

All of this information must be submitted in a uniform manner that CMS plans to publish at a later date. CMS also plans to provide training for the reporting specifications. SNFs will submit the information at least quarterly. Noncompliance may result in monetary penalties or exclusion from the Medicare and Medicaid programs.

While APTA supports the collection of this information for physical therapy staff working in the skilled nursing facility, we do have some concerns regarding the manner in which this information will be collected and for what purpose. We believe that data should be collected in an all-inclusive and meticulous manner that represents the complete assessment of care furnished in the SNF setting. In 2005, CMS initiated the Staff Time and Resource Intensity Verification (STRIVE) Project. This data subsequently derived from this project was used to make significant revisions to the SNF PPS and Resource Utilization Groups (RUG) –III model under Medicare and Medicaid.

APTA was very involved in this process and participated in the Open Door Forum and Technical Expert Panels held by the CMS contractor, the Iowa Foundation for Medical Care. Although this study yielded some useful information to CMS, we believe that there were many flaws in its execution. Namely, the staff categories in which information was collected on was not clear. For example, a category for staff hours for physical therapist assistants was not delineated in the data. Secondly, the project had several technical issues in the submission of data which led to incomplete assessment of therapy use in the SNF setting and how it related to payment.

While we are encouraged that this study plans to collect this information in an electronic and uniform manner, we still believe that inherent risks for flawed data still exists. Therefore, we strongly urge CMS to adhere to the following:

- 1) Convene a technical expert panel to design a structure and to clearly articulate the goals and purpose of the collected information prior to mandated reporting.
- 2) Only count staffing data that represents a complete episode of care from admission to and discharge. CMS should distinguish those cases in which an unexpected readmission or inpatient hospital stay occurred.
- 3) Clearly delineate all staff categories including physical therapist and physical therapist assistants.
- 4) Provide feedback reports to all applicable facilities prior to public reporting and provide an appropriate timeframe for facilities to dispute any information they believe is inaccurate.
- 5) If a SNF is found to be non-compliant with the reporting requirements, there should be an escalated appeals process afforded to the SNF prior to imposition of a civil monetary fine or exclusion from a federal healthcare program.

Advancing Health Information Exchange in SNFs

CMS notes the importance of the adoption and spread of health information exchanges in the SNF environment and across the care continuum and highlights the important work that the federal government has undertaken in recent years. APTA is committed to advancing the safety and quality of healthcare through health information technology (HIT) innovation and we are eager to work with the CMS, the Office of the National Coordinator for Health Information Technology (ONC) and other governmental agencies on health information technology's evolving role in promoting health, health care reform and health information exchange.

APTA is committed to the adoption of electronic health records (EHR), implementation and enforcement of privacy and security protections, and utilization of electronic health information to support new payment models such as accountable care organizations, as well as fostering health information exchange where it is not currently taking place, supporting coordinated patient-centered quality care through utilization of electronic health information, and being an active participant in the evolution of an interconnected electronic health system. APTA has many member physical therapists who have implemented electronic health record systems in their practices, despite not being defined as "eligible providers" (EPs) to receive meaningful use incentives under the Medicare and Medicaid programs.

Physical therapists play a critical role in a patient's continuity of care as the patient transitions from one health care setting to another. Physical therapy services are provided in a variety of settings, including home care, hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; Intermediate Care Facilities for People with Mental Retardation (ICF/MR); patients' education or research centers, hospices and schools. Physical therapy efficiently aids a beneficiary in gaining the best possible function within the context of their medical condition. These services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

With this expertise, physical therapists are essential participants in health care integration. Their assessment and plan of care for the patient is critical to reducing complications, particularly in

the LTPAC community and, therefore, it is important that information from each care team member at the varying settings is captured and exchanged based on the specialist's area of expertise to optimize patient outcomes and reduce miscommunication among the varying providers the patient will see throughout the course of care.

Consistency in Regulations across PAC Settings

We urge CMS to be mindful that in order to create a cohesive post-acute care payment system there must consistency among documentation and billing requirements. Therefore, post-acute care reform must be supplemented by meaningful and carefully crafted regulations that reduce redundancies, eliminate administrative burden, and increase efficiency. In tandem with quality measure development, CMS should conduct a comprehensive analysis of existing rules and regulations. As a result of this analysis, CMS must eliminate or significantly revise current regulations, included but not limited to the home health functional reassessment, SNF Change of Therapy OMRA, SNF 3-day hospital stay admission requirement, definitions of group and concurrent therapy, IRF short stay policy and IRF 60 percent rule. The elimination or revision of onerous regulations should take place prior to full implementation of the new payment model.

Conclusion

In conclusion, APTA thanks CMS for the opportunity to comment on the Skilled Nursing Prospective Payment System proposed rule (FY 2016), 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 regarding the proposed payment policies, staffing data collection or health information exchanges, please contact Roshunda Drummond-Dye, Director of Regulatory Affairs, at (703) 706-8547 or roshundadrumsmond-dye@apta.org. If you have questions regarding our comments on the SNF quality reporting program, please contact Heather Smith, Director of Quality at (703) 706-3140 or heathersmith@apta.org.

Sincerely,



Sharon L. Dunn, PT, PhD, OCS
President

SLD: hls, rdd