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Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1679-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically

RE: CMS-1679 P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal To Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020

Dear Administrator Verma:

On behalf of the more than 95,000 physical therapist, physical therapist assistant, and students of physical therapy members of the American Physical Therapy Association (APTA), I appreciate the opportunity to submit the following comments in response to the Centers for Medicare and Medicaid Services' (CMS) Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Fiscal Year (FY) 2018 proposed rule. Physical therapy is an integral service within the SNF setting, where physical therapists furnish medically necessary services to Medicare beneficiaries to improve their overall health and function, and to optimize their quality of life.

For FY 2018, CMS is proposing a 1.0 percent market basket increase as required by Section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015. This will translate to an increase in payments to SNFs of $390 million. APTA recognizes that CMS is statutorily mandated to increase the market basket by only 1.0 percent for FY 2018, however, in future rulemaking we ask CMS to recognize the robust resources needed to treat SNF patients, and to take this into account when determining future market basket increases.

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

Revising and Rebasing the SNF Market Basket Index

For FY 2018, CMS is proposing to rebase the market basket update to reflect 2014 Medicare-allowable total cost data from freestanding SNFs and to revise applicable cost categories and price proxies to determine the market basket. Previously the base year had been 2010. APTA supports the proposal to rebase and revise the SNF market basket with 2014 as the base year, as we believe that it will increase the accuracy of payments to SNFs.

SNF Quality Reporting Program (QRP)

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires the implementation of a QRP for SNFs. CMS is proposing that beginning with FY 2018, a penalty of a 2.0 percentage point reduction to the SNF market basket percentage would be applied to SNFs that do not satisfy the reporting requirements for the FY 2018 SNF QRP.

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, resource use, and other measures, with respect to certain domains, no later than the specified application date that applies to each measure domain and PAC provider setting. PAC providers must use risk-adjusted standardized assessment tools that are endorsed by the National Quality Forum (NQF) as the data source for quality measures. These standardized assessment tools must be incorporated into existing setting specific assessment tools (OASIS, IRF-PAI, and MDS).

APTA supports CMS's goal of improving the quality of health care for Medicare beneficiaries. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice. Furthermore, APTA believes it is essential that we develop a core set of functional measures to assess patients consistently across the continuum of care. APTA is pleased that the proposed SNF measures are in alignment with the IMPACT Act provisions. We offer the following comments on the proposed measures.

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

CMS is proposing to replace the current pressure ulcer quality measure; *Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678),* with a modified pressure ulcer measure; *Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.* APTA supports this alteration.

The modified version, unlike its predecessor, includes new or worsened unstageable pressure ulcers, including deep tissue injuries (DTIs), in the measure numerator. The proposed modified version of the measure also contains updated specifications intended to eliminate redundancies in the assessment items needed for its calculation and to reduce the potential for underestimating the frequency of pressure ulcers. The modified version of the measure would also satisfy the IMPACT Act domain of skin integrity and changes in skin integrity. For the aforementioned reasons, APTA believes that the replacement pressure ulcer quality measure is an improvement over the old measure and supports its inclusion within the SNF QRP.

CMS is also proposing to adopt four new measures that address functional status for FY 2020:

- Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)

- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)

- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)

- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

APTA supports the adoption of these outcome measures.

Potential Future Measures

Within the proposed rule, CMS states it is considering modifications to the discharge to community measure in the future. CMS notes it is currently unable to accurately identify baseline nursing facility residents as the current version of the measures is calculated via claims data. The agency has stated that potential future modifications of the measure could include assessment of the feasibility and impact of excluding baseline nursing facility residents from the measure through the addition of patient assessment-based data. APTA is supportive of this change as we believe it will increase the accuracy of the measure.

Standardized Assessment Data

Overall, APTA supports the standardized assessment data as proposed for the areas of cognitive function and mental status, impairments of hearing and vision, and special services, treatments, and interventions. APTA believes that many of the data elements are essential for appropriate risk adjustment of cases both for the purposes of payment and for use in outcomes measures methodologies in the PAC settings.

APTA appreciates that CMS has strict deadlines for the implementation of cross-setting standardized assessment data under the IMPACT Act; however, as many of these data elements will be new to the respective PAC settings, we encourage timely, appropriate education and training for providers to ensure that there is interoperability following full implementation. We believe that achieving a standardized and interoperable patient assessment data set and stable quality measures as quickly as possible will allow for better cross-setting comparisons as well as for the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of the IMPACT Act.

Over the last several years, CMS has been working to integrate the new data elements into the various PAC setting in compliance with the requirements under the IMPACT Act. However, we have increasing concerns about data element overlap and the number of data elements outlined under various proposed rules and calls for comments. We acknowledge that there are elements still under development; however, we strongly recommend that CMS publish the full data set for review and comment. Given the multiple calls for comments on various sections of the data set, it is becoming increasingly difficult to provide meaningful feedback. We believe that CMS would receive more robust comments if we could view the data set in its entirety – regardless of the phase of development.

Lastly, while we support the standardized data elements, we request CMS provide stakeholders with feedback on how this data may be used in the future. APTA has acknowledges the importance of the data elements and believes they should be used in risk adjustment methodologies for payment and quality measures. However, we have concerns about the use of these data elements to construct outcomes measures that will be used to determine payment. We encourage CMS to continue to work with stakeholders in the development of future quality measures for PAC settings.

Recoding

Additionally, APTA has concerns regarding the methodology for counting the "change" score. We are concerned about recoding all of the items "not assessed" to a '1,' as we believe this may be a point of significant gaming for some providers – e.g., rather than taking time to assess an item in the first three days, providers will score it as not tested, resulting in a falsely inflated change score. We encourage CMS to monitor this practice in the future to ensure the score is reflective of a provider's change score.

Accounting for Social Risk Factors

In the proposed rule, CMS seeks public comment on whether to account for social risk factors in the SNF Value-Based Purchasing (VBP) program, and what method or combination of methods would be most appropriate for accounting for social risk factors.

APTA recognizes that adjusting for social risk factors in certain outcome measures is a complex issue. APTA appreciates that the lack of adjustment for social risk factors in outcome measures utilized in value-based payment programs and models negatively

impacts providers and facilities in certain geographic areas where the incidence of specific social risk factors are highest. However, we also acknowledge that implementing social risk factor adjustments may increase health disparities by essentially masking these factors. Currently, outcomes measures are not adjusted for social risk factors, which has led to reduced payments for providers and facilities caring for large numbers of disadvantaged patients. In addition to financial repercussions, these publically reported outcome measures can be misleading to consumers.

APTA is an active member of NQF and has been following the social risk factor adjustment project; our organization has also reviewed the work performed by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine. APTA supports the overarching strategies outlined in the ASPE report, which include: Measure and report quality for beneficiaries with social risk factors; set high, fair quality standards for all beneficiaries; and reward and support better outcomes for beneficiaries with social risk factors. APTA encourages CMS to take immediate action on these recommendations. We support testing of social risk factor adjustment models as well as the reporting of stratified outcomes measures to providers to enable them to better understand the effects social risk factors have on their performance. Once the risk-stratified data has been shared with providers, we recommend that CMS work with stakeholders to share this data with the public.

APTA believes that the understanding of social risk factors and their impact on the health care system will continue to evolve over time. We encourage CMS to be responsive to future developments and strategies that provide solutions for adjustment of social risk factors in outcomes measures.

VBP Measure Transition

In previous rulemaking, CMS proposed to adopt the SNF 30-Day Potentially Preventable Readmission Measure, (SNFPPR), as the all-cause, all-condition readmission measure that would be used in the SNF VBP Program. This measure assesses the risk-standardized rate of all-cause, all condition, potentially preventable inpatient hospital readmissions of Medicare fee-for service SNF patients within 30 days of discharge from an acute care hospital, critical access hospital (CAH), or psychiatric hospital. This would replace the SNF 30-Day All-Cause Readmission Measure (SNFRM) currently in use. CMS indicates within the rule that the first opportunity to replace the SNFRM would be FY 2021 but is seeking comment on when it would be appropriate to replace the SNFRM with the SNFPPR.

In previous comments, APTA supported the adoption of the SNFPPR, as it is consistent with other CMS readmission measures in the PAC and acute care settings. Reducing acute care hospital readmissions for all SNF patient populations will decrease cost, improve patient safety, and promote the best possible outcomes for these patients. APTA has no objection to CMS implementing SNFPPR in FY 2021 if possible, and believes that the measure should be adopted when it is practical to do so.

APTA encourages CMS to include additional measures in the future that will round out the VBP profile, including measures that examine resource use and outcomes, such as functional outcomes and return to the community following discharge.

Request for Information (RFI)

APTA appreciates CMS's efforts to transform the health care delivery system, including the Medicare program, by emphasizing a strong focus on patient-centered care. We are encouraged by CMS's efforts to solicit ideas from stakeholders on policies and practices to help the Medicare program achieve transparency, flexibility, program simplification, and innovation. In response to the RFI, APTA recommends the following:

Telehealth

As Medicare payment shifts to innovative, valued-based payment methods, it is important to recognize the use of telehealth as a valuable tool for providers to improve the quality of care. Telehealth offers patients increased access to providers that might not be available otherwise, as well as medical services without the need to travel long distances. Telehealth consists of electronic communications to deliver a host of health related information and health care services including, but not limited to, physical therapy-related information and services, over large and small distances. Telehealth encompasses a variety of health care and health promotion activities ranging from education, advice, reminders, interventions, and monitoring of interventions. Telehealth is projected to reach 12 million users in 2022, according to the World Market of Telehealth.

With the increasing reliance of technology to improve access to quality care, APTA urges CMS to revisit its policies that address coverage of telehealth services to include services provided by physical therapists. Applications of telehealth in physical therapy expand throughout patient care and consultation, as it allows physical therapists to effectively communicate with patients and provide more flexible care. Expanding Medicare coverage of telehealth services to include physical therapy will ultimately allow physical therapists to provide services to patients in a greater capacity.

Moreover, as CMS pursues the development of future alternative payment models that emphasize both quality and multi-disciplinary service delivery, CMS should address gaps in its policies to provide increased Medicare coverage for telehealth services. Expansion of telehealth coverage to include physical therapy and other specialized health services would allow for more flexible care delivery to Medicare beneficiaries in need of comprehensive care from a team of providers. In addition, coverage for telehealth across a variety of providers can improve patient outcomes, decrease families' out of pocket spending, and promote greater adherence to rehabilitation programs. Telehealth also can promote increased collaboration among providers and social service institutions to better address the specific needs of patients the complete care continuum, from the primary care visit, to the rehabilitation services necessary to promote and maintain positive outcomes.

Physical therapy provided via telehealth can reduce costs, increase access to necessary care, enhance the patient's rehabilitation experience in the home environment, and prevent hospital readmissions. Although physical therapy is not included as a covered telehealth service under the Social Security Act Section 1834(m), we believe CMS has the authority to allow coverage and reimbursement for these telehealth services under new alternative payment models. Therefore, as CMS continues to develop new and innovative models, we encourage the agency to maximize the ability of multiple types of providers, including physical therapists, to have the flexibility to use telehealth services to effectively manage patient care.

Congress also has expressed an interest in allowing coverage under Medicare for physical therapy services delivered through telehealth. We are hopeful that Congress will pass legislation in the near future that permits coverage of telehealth services furnished by physical therapists, speech-language pathologists, occupational therapists, audiologists, and respiratory therapists to Medicare beneficiaries.

Therapy Cap

APTA strongly believes that hospitals should be appropriately reimbursed for the services they provide during the inpatient and observation periods. The decision to admit should be based solely on the clinical condition of the patient and the setting in which their medical needs can be safely and effectively addressed. However, one policy that continues to impact this decision-making is the therapy cap. Per statutory requirements, CMS places an annual per-beneficiary Medicare financial limitation on outpatient therapy services (therapy cap). Each year this annual amount is updated, and the 2017 therapy cap amount is $1,980 for physical therapy and speech language pathology services combined.

Due to the confusion that still exists around inpatient admission criteria, APTA continues to be concerned about coverage for therapy provided on an inpatient basis that is later denied by auditors and rebilled under Part B. Often, due to the risk of denials when classifying patients for an inpatient stay, there are instances in which a patient's entire stay in the hospital(s), which sometimes spans as many 16 days, is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period are counted toward the cap. We believe this is unfair to these patients, as it may limit their access to physical therapy in the outpatient setting when in fact these services should have been billed as inpatient services.

We strongly encourage CMS to establish an exception to the outpatient therapy requirements, as outlined in the Medicare Benefit Policy Manual, for observation status patients.

Another Part B payment policy that poses serious implications for patients and providers during an outpatient hospital stay is therapy functional limitation reporting. The *Middle Class Tax Relief Act* mandated that as of July 1, 2013, CMS collect information on claim forms regarding beneficiaries' function and condition. All practice settings that provide outpatient therapy services must include this information on their claim forms.

Specifically, the policy applies to physical therapy, occupational therapy, and speech-language pathology services furnished in hospitals, critical access hospitals, SNFs, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians, and non-physician practitioners.

Under the functional limitation reporting requirement for outpatient therapy services, non-payable G-codes and modifiers are mandated on the claim forms to capture data on the beneficiary's functional limitations at the outset of the therapy episode, at a minimum of every 10th visit, and at discharge. The ability to clearly discern whether the patient is receiving services under the outpatient therapy benefit or as part of the patient's inpatient stay is critical to compliance for hospitals under functional limitation reporting requirements, which makes reporting under observation status all the more complicated. Therefore, we strongly urge CMS to waive functional limitation reporting for observation status patients. CMS could establish this exemption with the use of a modifier when billing. This same modifier could be affixed to therapy services billed under observation status as well as when rebilled under Part B for denied admissions.

Policies such as the therapy cap and functional limitation reporting were intended for patients receiving therapy in the outpatient setting, and are nonsensical in their application to patients in observation status. We believe that addressing payment and defining these categories will help to ensure patient access to outpatient therapy is not unreasonably limited, while also helping hospitals maintain continuous compliance with Medicare rules and regulations.

SNF Three-Day Waiver

APTA strongly recommends that CMS modify the SNF three-day inpatient stay requirement to allow days spent in observation be considered for satisfying the three-day inpatient hospital stay requirement for Part A coverage of SNF care. Congress has also expressed support for such a policy change, as members in both the House and Senate have introduced the *Improving Access to Medicare Coverage Act of 2017* (H.R. 1421/S. 568). The legislation expands the definition of inpatient for purposes of the three-day inpatient stay requirement, and allows time spent in observation to count towards satisfying the requirement.

Local Coverage Determination (LCD) Transparency

Another area in which to increase efficiency in the Medicare program would be to require Medicare Administrative Contractors (MAC) to enhance efforts at transparency when creating Local Coverage Determinations (LCDs). Currently, MACs are given broad authority to decide whether to cover an item or service when they develop an LCD. While an LCD cannot contradict a National Coverage Determination (NCD), many MACs adopt the same or similar LCD, effectively creating uniform coverage determinations nationwide.

APTA recognizes that MACs are well within their authority to determine whether to cover an item or service. The concern is that many MACs are opaque when crafting LCDs, and many determinations feel arbitrary and unsubstantiated by fact or academic research. Similarly, in our experience, comments concerning draft LCDs and questions regarding the process have often gone unanswered and ignored. CMS's Program Integrity Manual instructs MACs on how to develop LCDs, but there are additional steps that could be taken to ensure that the process is more transparent, and takes into account input from affected stakeholders.

Recently, the *Local Coverage Determination Clarification Act of 2017* was introduced in the Senate (S. 794). Under the legislation, MAC Carrier Advisory Committee meetings would be required to be open to the public and on the record. The bill would also require MACs to describe the evidence considered when drafting an LCD as well as the rationale they rely on should they deny coverage, as well as prohibit a single MAC from making determinations to be used on a nationwide basis on a given specialty.

APTA supports the *Local Coverage Determination Clarification Act of 2017.* We do not feel that it is necessary, however, for legislation to be passed in order to improve the LCD process. It is within CMS's power to require MACs to comply with many of the measures that are proposed in the *Local Coverage Determination Clarification Act of 2017.*

Compelling MACs to comply with these measures will not have a negative impact on the MACs profitability or operational status. Rather, implementing such requirements would ensure that LCDs are created in a transparent manner that involves all stakeholders. This will lead to a more efficient coverage process and ultimately, improved patient outcomes.

Conclusion

In conclusion, APTA thanks CMS for the opportunity to comment on the FY 2018 SNF PPS proposed rule. We look forward to working with the agency to craft patient-centered payment policies that promote the delivery of quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Kyle Levin, Regulatory Specialist, at kylelevin@apta.org or 703/706- 8549.

Sincerely,

Sharon L. Dunn, PT, PhD
President

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