June 22, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Attn: CMS-1696-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 (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program (CMS-1696-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 regarding the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing (VBP) Program, and SNF Quality Reporting Program (QRP) proposed rule. 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 otherwise 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 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.

As stated in previous comment letters, APTA strongly believes the frequency and duration of physical therapy services should be based solely on the needs of the patient. We appreciate 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 form a stakeholder workgroup to engage with CMS 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.

Recommendations

**PDPM**

- APTA recommends CMS adopt a transparent PDPM implementation process. We also recommend the agency form a stakeholder workgroup to support the agency in its efforts to effectuate the PDPM.
- APTA does not support the proposed PDPM ICD-10 diagnosis approach to report information on the Minimum Data Set (MDS), or the use of the MDS section I0020 option to determine the physical therapy and occupational therapy clinical category. APTA recommends an alternative MDS checklist item set approach to determine the physical therapy and occupational therapy clinical category under PDPM.
- APTA supports the revised CMS approach to use MDS Section GG items rather than Section G items to represent resident function at admission for PT and OT Component case-mix adjustment purposes.
- APTA recommends that CMS include comorbidities as a factor in the physical and occupational therapy case-mix classifications. We also encourage CMS to review more data to determine whether cognitive status should be included as a factor in classifying residents under the PDPM.
- APTA supports CMS’s efforts to reduce burden on providers, but encourages CMS to modify the Interim Payment Assessment (IPA) to reduce the complexities and remaining questions associated with operationalizing it.
- APTA recommends CMS permit the reset of the non-therapy ancillary (NTA) services per diem rate upon IPA completion.
- APTA supports CMS’s proposal to use Section O to monitor therapy utilization. We also recommend that in evaluating the impact of PDPM implementation on therapy service delivery patterns, CMS do so in the context of the impact on CMS-developed quality and outcomes measures that are commonly associated with effective rehabilitation services.
- APTA encourages CMS to reinforce the importance of physical therapist and other clinician’s clinical judgment within future rulemaking. We also support CMS’s intent to monitor group and concurrent therapy utilization as well as patient outcomes.
following implementation of the 25 percent combined group and concurrent limit as well as CMS’s proposal for therapy minutes in the PDPM to be reported by unallocated beneficiary time receiving therapy services regardless of individual, concurrent, or group therapy delivery modes.

- APTA recommends that CMS redefine group therapy under PDPM to be consistent with the Inpatient Rehabilitation Facility (IRF) definition of 2-6 residents.
- APTA recommends that CMS revise the concurrent and group therapy combined limit policy when students are involved to ensure SNFs are not dis-incentivized from accepting and training therapy students.
- APTA requests that CMS clarify the interrupted stay policy.
- APTA recommends that CMS implement the PDPM in a budget-neutral manner. APTA also recommends CMS ensure the therapy non-case-mix rate is captured within the PDPM.
- APTA encourages CMS to formalize a transparent process and timeline to refine the PT and OT Component case-mix determination approach soon after the implementation of PDPM to assess whether certain factors would influence the ability of the model to better predict PT and OT resource use.
- APTA recommends that CMS adopt an outlier payment system.

**SNF QRP**

- APTA encourages CMS to be responsive to future developments and strategies that provide solutions for adjustment of social risk factors in outcomes measures.
- APTA supports the addition of the new measure removal factor for previously adopted SNF QRP measures.
- APTA supports CMS’s proposed policies regarding public display for the SNF QRP.

**Request for Information (RFI)**

- APTA’s comments in response to the RFI reflect the issues we have identified as a profession with respect to health IT adoption and interoperability.

**Revising and Rebasing the SNF Market Basket Index**

Section 5311 of the Bipartisan Budget Act of 2018 amended section 1888(e) of the Social Security Act (Act) to add section 1888(e)(5)(B)(iv) of the Act. Section 1888(e)(5)(B)(iv) of the Act establishes a special rule for FY 2019 that requires the market basket percentage, after the application of the productivity adjustment, to be 2.4 percent. In accordance with section 1888(e)(5)(B)(iv) of the Act, CMS proposes to use a market basket percentage of 2.4 percent to update the federal rates set forth in this proposed rule. APTA supports the agency’s proposal.

**Proposed Revisions to SNF PPS Case-Mix Classification Methodology**

APTA appreciates CMS’s efforts to ensure 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.
PDPM Implementation Timeline

Provide Details of Transition Strategy
APTA is encouraged by CMS’s statement that PDPM implementation will not occur until FY 2020, to ensure there is a sufficient amount of time to allow for provider education and training, internal system transitions, and to allow states to make any necessary Medicaid program changes. Within the rule, CMS states that it will continue to provide free software to providers which can be used to group residents under the proposed PDPM, as well as data specifications for this grouper software as soon as is practicable, should the proposed PDPM be finalized, thereby mitigating potential concerns around software vendors having sufficient time to develop products for PDPM. APTA supports CMS’s intentions to share data specifications for the grouper software as soon as possible. To further aid electronic health record (EHR) vendors, as well as providers, patients, and CMS contractors, in their efforts to prepare for this significant system change, we also recommend that CMS provide details surrounding its intended PDPM transition strategy and the associated timeline. Following PDPM implementation, we also recommend that CMS closely monitor the processing of SNF claims, to ensure claims are handled appropriately and providers do not experience processing delays or unwarranted denials.

Develop Advisory Stakeholder Workgroup
As recommended above, as CMS moves forward with the process of implementing the PDPM, including the updating of interpretive guidance, Medicare manuals, MLN articles, and the MDS Resident Assessment Instrument (RAI) Manual, we encourage the agency to form a stakeholder workgroup to engage with CMS in a transparent and meaningful manner. Soliciting input and engaging in meaningful dialogue with stakeholders, including APTA, will support CMS in its efforts to effectuate the PDPM.

Proposed Physical and Occupational Therapy Case-Mix Classification

Use of ICD-10 Codes to Categorize Residents into Clinical Category Raises Compliance Concerns
CMS proposes to require the reporting of the ICD-10-CM and ICD-10-PCS codes to determine the clinical category within the Physical Therapy, Occupational Therapy, and Speech-Language Pathology Components (PT, OT, and SLP Components). APTA appreciates CMS’s efforts to ensure residents are appropriately categorized under the PDPM by requiring SNFs to include the ICD-10-CM diagnosis and inpatient surgical procedure (ICD-10-PCS) to assign a resident to the appropriate surgical or non-surgical clinical category. However, we have concerns that connecting the clinical categories to ICD-10-CM and ICD-10 PCS codes may not adequately capture the range of conditions impacting the residents; it also creates unnecessary complications and adds significant administrative burden on the provider. The ICD-10 codes are often not readily available, and SNFs that do not have interoperability with their referral hospitals and physician offices will face challenges in identifying and obtaining the correct ICD-10 codes. We encourage CMS to consider the difficulties associated with accurate coding, which in the SNF setting is compounded by the fact that the majority of SNFs do not have certified coders on staff. The MDS RAI Manual also will need to be revised to incorporate detailed instructions on how clinicians should best identify the “primary reason,” which will ultimately dictate the resident’s clinical categorization under the PDPM.
APTA envisions that requiring ICD-10-CM (and ICD-10-PCS) coding will pose significant administrative, financial, and compliance burdens on SNFs. The potential for error is high, likely leading to inaccurate categorization and thus, misalignment between resource need and reimbursement. Therefore, we urge CMS to consider an alternative option to the reporting of these codes. Specifically, APTA recommends that instead of requiring the reporting of these ICD-10 codes, CMS add checklist items to Section I of the SNF PPS admission MDS for providers to report the primary condition for classification under the PT, OT, and SLP Components.

**Adopt an Alternative Option for Clinical Categorization**

APTA is supportive of an approach that would allow the SNF the option to enter all required patient PT, OT, and SLP Component clinical category classification information on the MDS via descriptive checklist, rather than fully-specified ICD-10-CM or ICD-10-PCS codes. Regardless of the reporting method, the medical record documentation supporting how the MDS items were reported are the same; moreover, CMS could direct SNFs to the RAI Manual for guidance. Additionally, the checklist option reduces significant administrative and compliance burden associated with identifying and justifying fully-described ICD-10-CM or ICD-10-PCS while having little or no impact on payment accuracy.

We also believe this approach would account for the presence of comorbidities and aid in proper categorization. Further, it would support future data analysis and refinement of the payment model. The MDS RAI Manual guidance could describe the clinical documentation that supports whether one of these condition items are checked as present, similar to how other existing MDS items are defined in the MDS RAI Manual. This proposal would remove much of the complexity and burden associated with identifying and mapping tens of thousands of diagnosis codes that could apply to the PDPM PT and OT case-mix weights. Additionally, the extensive collapsing of the PT and OT conditions into only 4 discrete primary level case-mix groupings significantly minimizes the risks of classification of the resident into the wrong payment group.

The SNF would answer the following questions in sequence and check all boxes that apply to the resident in a new MDS Section I sub-section. The PDPM grouper would select the clinical category with the highest case-mix index for the PT and OT case-mix groups, and apply the “Acute Neurologic” results to the SLP case-mix determination logic. An example of this checklist approach might look like the following:

**MDS Questions for Determination of PDPM Primary Clinical Categories**

During an acute care hospital or CAH hospital prior to the SNF admission did the resident:

1. Undergo a major joint replacement to any of the following structures (Hip, Knee, Ankle) or undergo surgery to spine (Lumbar, Thoracic, Cervical) or to the spinal cord?
   1. If yes, check the “Major Joint Replacement or Spinal Surgery” PDPM clinical category box.
2. Undergo a surgical procedure (including amputation) to any joint or bone not associated with the “Major Joint Replacement or Spinal Surgery” PDPM clinical category?
   1. If yes, check the “Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)” PDPM clinical category box.
3. Receive medical and/or surgical treatment for a disorder to the brain, or medical (non-surgical) treatment for a disorder of the spinal cord?
   1. If yes, check the “Acute Neurologic” PDPM clinical category box.
4. Undergo a surgical procedure not associated with the “Major Joint Replacement or Spinal Surgery,” “Orthopedic Surgery,” or “Acute Neurologic” PDPM clinical groups?
   1. If yes, check the “Non-Orthopedic Surgery” PDPM clinical category box.
5. Receive non-surgical treatment related to bone, muscle, or connective tissues (e.g. cartilage, ligaments, tendons)?
   1. If yes, check the “Non-Surgical Orthopedic/Musculoskeletal” PDPM clinical category box.
6. Receive non-surgical treatment related to an acute infection?
   1. If yes, check the “Acute Infections” PDPM clinical category box.
7. Receive non-surgical treatment related to a pulmonary condition?
   1. If yes, check the “Pulmonary” PDPM clinical category box.
8. Receive non-surgical treatment related to a cardiovascular or blood clotting conditions?
   1. If yes, check the “Cardiovascular and Coagulations” PDPM clinical category box.
9. Receive non-surgical treatment related to cancer?
   1. If yes, check the “Cancer” PDPM clinical category box.
10. Receive non-surgical treatment related to any condition not included in the above listed PDPM clinical categories?
   1. If yes, check the “Medical Management” PDPM clinical category box

APTA urges CMS to adopt a clinical category checklist rather than requiring SNFs to correctly code for ICD-10-CM or ICD-10-PCS on the MDS.

Should CMS disagree with this approach, we offer the following comments related to the agency’s ICD-10 proposal:

APTA Seeks Clarification on Correctly Identifying ICD-10 Codes

APTA requests that CMS clarify within final rulemaking what medical records SNFs may rely on to determine the principal reason for the SNF stay and/or inpatient surgical procedure and how it expects clinicians to best identify these codes. We encourage the agency to revise the MDS RAI Manual to include guidance on this issue. If the agency intends for SNFs to rely solely on hospital records, it is important to note that frequently the SNF does not receive the complete hospital records and/or the hospital does not promptly finalize the applicable ICD-10 codes for billing purposes until after the resident is discharged from the SNF. This is likely to lead to incorrect coding and a delay in completion of the MDS beyond the 8-day window. For example, the delay in communication between the hospital and post-acute care facility was a significant difficulty identified by post-acute care facilities participating in the Bundled Payment for Care Improvement Initiative (BPCI) Model 3. Such coding and communication uncertainty led to misinterpretations as to when a beneficiary was included within the episodic-payment model.

To aid SNFs in their coding efforts, APTA encourages CMS to finalize 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.

Should CMS not finalize and effectuate the hospital discharge planning rule in advance of PDPM implementation, we recommend that CMS require hospitals to provide diagnostic and procedural information at the time of the patient’s discharge, or within 48 hours following discharge, to the receiving facility to ensure SNFs receive the appropriate information from the transferring hospital in a timely manner. Specifically, CMS should require hospitals to transfer medically necessary information (to be defined) to another facility upon a patient transfer or discharge and do so electronically; require that these facilities send required discharge information to the SNF via electronic means if possible; and require that such providers make certain information available to patients or a specified third-party (for example, required discharge instructions) via electronic means if requested. We also suggest that CMS require hospitals to establish discharge plans for all patients and follow prescribed time frames for completing the evaluation and discharge plans and transmitting the information to the receiving facility.

The ease of electronic submission of this information is critical in discharge planning and transitions in care. APTA is committed to the adoption of EHRs, 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 pending implementation of the proposed PDPM strongly reinforces the need for CMS to increase its efforts to advance interoperability between providers.

Additionally, while we appreciate CMS’s approach to ensure appropriate categorization based on patient characteristics, requiring a clinician to list the ICD-10-CM and ICD-10-PCS on item I8000 poses significant challenges for the physical therapist or other clinician completing the 5-Day MDS. While the acute care hospital and IRF payment systems have relied on ICD-10 coding for their payment, SNFs have little familiarity with the system(s). Due to this lack of knowledge as well as significant complexity underlying the ICD-10-CM and ICD-10-PCS coding systems, physical therapists and other SNF staff will be required to receive significant and periodic training in diagnosis and procedure coding, taking time away from direct patient care. Moreover, physician documentation within the record may not directly correlate to the ICD-10-CM or ICD-10-PCS definition, placing the onus on the physical therapist or other SNF clinician to recognize and select the most appropriate codes. And in instances where multiple procedure codes are listed within the medical records, we have concerns that SNFs will be penalized if the “correct” procedure code is not included on the admission assessment. APTA recommends that CMS clarify within final rulemaking how clinicians will be expected to choose the most appropriate procedure code when multiple procedure codes are included in the record as well as hold medical reviewers to these instructions. We also encourage the agency to discuss in final rulemaking how it intends SNFs to reconcile a potential lack of complete and/or accurate documentation if payments to SNFs hinge upon the ICD-10-CM (and ICD-10-PCS) recorded within the 5-Day MDS.
Finally, APTA has significant concerns that if categorization into a clinical category hinges on one or two ICD-10 codes, when hospitals modify the diagnosis or inpatient surgical procedure code(s) subsequent to completion of the 5-Day MDS, Medicare review contractors may utilize this discrepancy in coding against the SNFs in medical review and audit. We question whether CMS will expect these ICD-10 codes to match the hospital codes, and how CMS will direct Medicare contractors and auditors to treat coding discrepancies. SNFs should not be held responsible and possibly subject to medical review for instances in which a hospital subsequently makes a change to the code(s) reported by the SNF on the MDS, as this is outside the control of the SNF. It would be unreasonable for a SNF to face potential penalization for an acute institution’s actions or inactions.

To ensure an equitable approach towards conducting medical review of SNF claims following implementation of the PDPM, we recommend: 1) In instances where payment would be impacted, CMS should include a mechanism to permit the diagnosis codes for the admission assessment to be corrected at any time prior to discharge in cases where necessary information at the time the admission assessment is completed is missing and/or permit the diagnosis codes to be updated on the discharge assessment; 2) CMS direct Medicare Administrative Contractors, Recovery Audit Contractors, and other contractors to make review of ICD-10-CM and/or an ICD-10-PCS codes on the MDS a low priority for medical record reviews; and 3) Should CMS move forward with adoption of coding the ICD-10 diagnosis code on the MDS I8000 and ICD-10-PCS on the second line item of the MDS I8000, we encourage CMS to offer free or subsidized ICD-10-CM and ICD-10-PCS training for SNF therapists, billers, coders, and other staff.

Insufficient Alignment between I0020 Primary Medical Conditions and Clinical Categories
APTA appreciates the ease associated with using I0020 to categorize a patient into 1 of the 4 clinical categories within the PT and OT Components. However, we have concerns that there is insufficient overlap between the I0020 primary medical condition categories and the 4 PT and OT clinical categories – major joint replacement or spinal surgery; non-orthopedic surgery and acute neurologic; other orthopedic; and medical management. There is not a natural alignment between the categories; moreover, the 14 categories exclude many conditions that are not only common among SNF residents, but correspond to the PDPM clinical categories, such as acute infections, cancer, and pulmonary. Moreover, the current I0020 item set was established specifically for the SNF QRP mobility and self-care outcome measures to be implemented on October 1, 2018. As such, while we are encouraged by the uncomplicated nature of the I0020 categories, we believe the existing I0020 item set is inadequate for determination of clinical classification within the PT and OT (and SLP) Components. Therefore, APTA opposes CMS’s proposal to utilize I0020 to categorize residents under the PDPM.

APTA Supports Utilization of Section GG to Determine Functional Status
APTA supports CMS’s proposal to replace Section G items with functional items from Section GG of the MDS 3.0 (Functional Abilities and Goals) as the basis for calculating the function score for resident classification use under PDPM. However, we seek clarification regarding CMS’s intention to crosswalk GG0170H1 (Does the resident walk?) to activity response “Resident cannot walk” under the proposed PT and OT scoring algorithm for the PT and OT functional measure, given this MDS item is being retired effective September 30, 2018.
APTA Seeks Clarification on Functional Status Scoring

APTA seeks clarification from CMS regarding the data Acumen analyzed to make the determination that residents unable to complete an activity had similar PT and OT costs as dependent residents, prompting Acumen to group “dependent” with “resident refused, “not applicable, and “not attempted due to medical condition or safety concerns” and assign these responses a score of 0. We question whether assigning a score of 0 to these 4 categories of residents may, to their detriment, falsely imply these residents have no functional potential. For example, a resident who has a recent stroke may be dependent upon admission. However, this resident likely has significant functional potential. Currently, Section GG is not collected at the 14-Day MDS; if it were, GG data may reflect a difference in resident ability. The lack of this functional status information on which to base a payment system is unfortunate, but should be taken into account. Failure to take this into consideration could unfairly categorize some residents into a lower paying category due to their lack of “functional ability,” therefore leading to misalignment between a resident’s need for services and reimbursement. It is imperative the new payment system is constructed in such a way that promotes the delivery of all necessary services throughout the length of the stay. Accordingly, APTA encourages CMS to consider whether assigning score of 1 to “dependent” will better ensure residents with functional potential are appropriately assessed and receive the necessary therapy volume, mode, and discipline(s). Further, assigning a score of 1 to “dependent” would align with scoring under the SNF QRP.

Include Comorbidities as a Factor in PT and OT Components

APTA has concerns that requiring a patient to be categorized into 1 of 4 clinical categories, based on items I8000 or I0020, could pigeonhole many of the vastly diverse and complex SNF patients into a category that may not fully represent their clinical condition(s) that necessitate the delivery of therapy services. Using the first line item on the I8000 to report the ICD-10 code which represents the primary reason for the patient’s SNF stay is severely restrictive in assessing a patient’s characteristics and need for physical therapy, as are the broad I0020 primary medical condition categories.

Currently, the MDS RAI Manual instructs providers to code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. The MDS RAI Manual recognizes there is likely a cluster or grouping of diagnoses that impact the resident’s current status as well as their needs in this setting. Neither the I8000 nor I0020 items capture the full depth of a patient’s condition, and hence, will not reflect the reason(s) for physical therapy (and other therapies). For example, a resident who fractured a hip 6 weeks prior and returns to the SNF with congestive heart failure exacerbation is likely to have more significant mobility or range of motion limitations than a resident who underwent a total hip replacement and 3 weeks later is receiving IV antibiotics for an infection.

Therefore, we encourage CMS to adopt a comorbidity proposal for the PT and OT Components. The agency could consider an approach similar to what it proposed in the Home Health Groupings Model (HHGM). Within the HHGM, CMS used broad categories and subcategories to group comorbidities. CMS identified a list of 15 broad body system categories; secondary diagnoses listed on the OASIS that attributed to any one of the listed subcategories would be
used to identify whether an episode would fall into one or more comorbidity categories and subcategories. If a comorbidity that fell within one of the 15 broad system categories was present, the episode received a payment adjustment.

Here, CMS could identify an overarching list of common chronic comorbidity diagnoses frequently cited as drivers of increased health care resource utilization that coincide with PT and OT utilization, such as coronary artery disease, congestive heart failure, diabetes, COPD, asthma, chronic wounds, and depression. When a resident has 1 or more PT and OT-related secondary diagnoses that crosswalk to the list of active diagnoses in Section I of the MDS RAI Manual, CMS could account for this comorbidity to ensure the PT and OT case-mix indices adequately align with the resident’s characteristics and therapy needs. Accounting for the presence of significant comorbidities will help to ensure residents who have conditions which necessitate the delivery of therapy, but may not be reflected within the I8000 diagnosis or I0020 primary medical condition category, are categorized into the most appropriate PT and OT case-mix groups and the SNF is appropriately compensated for therapy services delivered, alleviating any concern that therapy services will be stinted due to financial pressures. It also will help to promote better consistency across post-acute settings, particularly as CMS moves towards a unified post-acute care system.

Finally, while APTA believes cognitive status also is a factor that significantly influences a patient-driven payment model, we acknowledge the data does not currently support its role in classifying residents under the PDPM. Given the changing practice patterns in identifying and treating cognitive impairments, prior and subsequent to PDPM implementation, APTA encourages CMS to review the latest data and consider making adjustments to the model to ensure it accurately reflects appropriate treatment and evidence-based practice.

**Assessments**

*APTA Supports Reduction in Administrative Burden but Recommends CMS Modify the IPA Proposal to Reduce Complexities*

APTA appreciates CMS’s proposal to reduce burden on SNFs by reducing the number of required assessments. CMS proposes to require providers to reclassify residents as appropriate from the initial 5-day classification using a new assessment, an IPA. Providers would be required to complete an IPA in cases where the following two criteria are met: (1) There is a change in the resident’s classification in at least one of the first tier classification criteria for any of the Components under the proposed PDPM, such that the resident would be classified into a classification group for that component that differs from that provided by the 5-day scheduled PPS assessment, and the change in classification group results in a change in payment either in one particular payment component or in the overall payment for the resident; and (2) The change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14-day period.

To ensure SNFs are appropriately compensated for the care of residents who may require greater resources, we recommend that CMS adopt a more simplified IPA policy. The purpose of the IPA is to document when a resident has had a significant change in status for either improvement or decline. However, we believe there are unnecessary, significant complexities associated with the
IPA, which needlessly increases the risk of provider error and potential medical review. Requiring SNF clinicians to ascertain a need for the IPA by consistently monitoring for a change in one of the first tier classification criteria that results in change in payment across the 5 components and is expected to persist at least 14 days poses a significant burden on clinicians, particularly given the difficulty associated with predicting whether or not the change in status will be resolved in 14 days. We have concerns the IPA will not fulfill CMS’s objectives for proposing the IPA, in that, an IPA will not be completed each time a resident has a significant change and hence, the SNF will not be appropriately reimbursed for care delivered to a resident. Consequently, this could lead to the stinting of care for residents with significant complexities due to the lack of alignment between payment and patient characteristics.

In an effort to promote appropriate utilization of the IPA, we recommend that CMS modify both IPA criteria. First, we recommend that CMS revise IPA criterion 1 to account for a significant change in function, or a change in therapy need, rather than solely accounting for a change in a resident’s classification in at least one of the first tier classification criteria. Functional status plays a significant role in resource utilization, rehospitalization, risk of mortality, and morbidity, and is an important quality to residents as well as their families/caregivers, and should be accounted for under the PDPM. For example, a resident upon admission who is unable to tolerate therapy has a subsequent change in functional status several days later. This change in status prompts the need for increased therapy volume or the involvement of additional therapy disciplines. However, under the current IPA definition, this scenario is unlikely to trigger the completion of an IPA; thus, we question how CMS anticipates a SNF may appropriately establish a change in a resident’s therapy needs in order to ensure adequate reimbursement.

Second, APTA recommends that CMS reduce the IPA time period criterion, such as to 7 days. We disagree with CMS’s proposal to only permit an IPA to be completed if the changes are such that the resident would not be expected to return to his or her original clinical status within a 14-day period. 14 days seems excessive, particularly given that CMS estimates the majority of stays under the PDPM will be between 1-15 days. Moreover, neither Acumen’s technical report nor the SNF proposed rule offers a rationale for instituting a 14-day window. Additionally, the 14-day timeframe fails to align with CMS’s rationale for adopting the proposed interrupted stay policy, wherein CMS believes that “3 days represents a reasonable window after which it is more likely that a resident’s condition and resource needs will have changed, and this 3-day requirement is also consistent with the interrupted stay policies of similar Medicare PAC benefits.”

Alternatively, CMS could adopt a straightforward approach similar to the change in status policy within the home health setting, which requires the completion of an assessment “when the

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patient experiences an event that meets your agency’s definition of a major decline or improvement in the patient’s health status.”

Adopting a more simplified, balanced method which identifies a change in a resident’s condition that requires additional resources not currently accounted for will better promote “treating in place.” Treating in place can be an effective strategy to improve the delivery of care, beneficiary outcomes and quality of life, and downstream resource utilization. As recently reported by Kaiser Health News, 1 in 5 Medicare beneficiaries transferred from the hospital to the nursing home is rehospitalized within 30 days. It is imperative that CMS institute policy changes which incentivize the delivery of care to residents “in place.”

**Permit Reset of NTA Services Per Diem Rate When IPA Completed**

APTA recommends that CMS allow for a reset of the variable per diem adjustment rate for NTA services upon completion of an IPA. We recognize CMS’s concerns that if the variable per diem adjustment schedule is reset each time an IPA is completed, providers may be incentivized to conduct multiple IPAs during the course of a resident’s SNF stay. Strictly disallowing a reset of the variable per diem adjustment schedule when an IPA is completed, however, may impose unreasonable financial burdens on SNFs with residents who suffer serious changes in condition unrelated to the initial reason for the SNF stay. Moreover, not permitting a reset of the NTA per diem rate upon completion of an IPA could incentivize readmissions to the hospital. To ensure that resident care is not compromised and SNFs are not unfairly penalized when residents experience a change in condition, we encourage CMS to permit the reset of the NTA variable per diem adjustment schedule when an IPA is completed.

**APTA Supports CMS’s Proposal to Add Section O to Discharge Assessment**

Under the proposed PDPM, CMS proposes to require that SNFs continue to complete the PPS Discharge Assessment, as appropriate, including the proposed items from Section O of the MDS to be added to the PPS Discharge Assessment for each SNF Part A resident at the time of Part A or facility discharge. This will allow CMS to continue to collect data on therapy provision to assure that residents are receiving therapy that is reasonable, necessary, and specifically tailored to meet their unique needs.

APTA supports CMS’s proposal to collect data from providers on the volume, type (physical therapy, occupational therapy and speech-language pathology), and mode (individual, co-treatment, concurrent, or group therapy) of therapy provided to SNF residents. We agree this will permit CMS to track therapy utilization under PDPM and better ensure that residents continue to receive an appropriate amount of therapy commensurate with their needs, given the reduction in the frequency of resident assessments required under the proposed PDPM. However, we encourage CMS to be mindful that the development of the PDPM was prompted by the Medicare Payment Advisory Commission (MedPAC) and the US Department of Health and Human Services Office of Inspector General’s long-standing belief that unnecessary therapy services

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have been delivered in the SNF setting due to the embedded financial incentives that exist within the SNF payment system. Thus, it is unreasonable to assume the overall amount of therapy delivered will not decline following implementation of the PDPM. While an accountability mechanism is both appropriate and necessary to require the tracking and submission of such data to ensure the provision of physical and other therapies to SNF patients are not inappropriately limited within the PDPM, APTA recommends CMS clarify its position on how it anticipates the provision of therapy will be impacted as a result of shifting resources under the new payment model.

In addition to CMS’s proposal to monitor the amount and intensity of therapy delivered to each resident by adding Section O items to the PPS discharge assessment, we recommend that CMS include quantitative and qualitative metrics, including meaningful performance-based and patient-reported outcome measures, within the SNF QRP and/or VBP Program that are more closely correlated to the delivery of physical therapy, occupational therapy, and/or speech-language pathology services. Specifically, APTA recommends that in evaluating the impact of PDPM implementation on therapy service delivery patterns, CMS do so in the context of the impact on quality and outcomes measures that are commonly associated with effective rehabilitation services. This will assist the agency in its efforts to ensure coordinated, patient-specific, outcome-based care is being delivered safely by properly qualified professionals.

Finally, APTA recommends that in the distant future, CMS consider the feasibility of requiring the tracking of rehabilitative versus maintenance therapy, similar to the home health setting. This data would be relevant to future discussions on changes in intensity/duration of therapy services delivered under the PDPM.

**Group and Concurrent Therapy**

*Reinforce the Importance of Deferring to Physical Therapists’ Clinical Judgment*

CMS proposes that concurrent and group therapy combined be limited to no more than 25 percent of a SNF resident’s therapy minutes by discipline. While APTA acknowledges that there exists a lack of data to demonstrate what may be considered the most appropriate threshold of group and concurrent therapy for each individual, we have concerns that setting an arbitrary limitation will hamper a physical therapist or other therapist’s ability to make appropriate treatment determinations. Setting a limitation on total group and concurrent therapy also may restrict some residents from being able to access the mode of therapy that best aligns with their needs, goals, and desires.

We recognize the need to ensure SNFs are not incentivized to emphasize group and concurrent therapy over individualized therapy, to the detriment of the resident. Given that it is the responsibility of the clinician to make judgments that are in the best clinical interests of the patient, we recommend CMS discuss 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 the patient, as medically necessary in accordance with Medicare coverage guidelines for skilled therapy. We strongly support CMS’s intent to closely monitor group and concurrent therapy utilization as well as patient outcomes following implementation of the 25 percent combined limit and urge the agency to leave open the opportunity to increase
the threshold in the future. We also support CMS’s proposal to report and count the resident’s time in therapy, rather than the therapist’s allocated time, as this is consistent with the principles of patient-centered care and clinical practice.

Align Group Therapy Definitions across Post-Acute Settings

Medicare payment and coverage policies should afford flexibility to physical therapists and other therapy professionals to develop an individualized care plan tailored to the needs of each patient. Therefore, we recommend that CMS revise the definition of group therapy to achieve greater alignment with group therapy as defined in IRFs. We request that CMS modify 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 not only promote consistency across Part A settings, but modifying the definition of group therapy also would allow physical therapists and other therapy professionals to exert greater authority in addressing each resident’s specific needs while ensuring residents continue to receive the majority of therapy services on an individual basis.

Use of Students in SNFs

While APTA supports setting a limit on group and concurrent therapy, APTA has concerns that maintaining compliance with the 25 percent combined limit will be difficult for SNFs when students are involved in the care of residents. Students’ minutes are often counted as concurrent therapy when the clinical instructor is also treating a patient and we anticipate residents being treated by students will quickly exceed the 25 percent threshold. Therefore, compliance with the 25 percent limitation of discipline specific concurrent minutes, could, when a student is present, make it inefficient for the supervising therapist/assistant and impede the willingness to take students in the SNF setting.

Post-acute care facilities rely on positive clinical education experiences which translate into quality therapists pursuing that setting upon graduation or early in their careers. Specifically, the SNF setting offers a unique opportunity for students to see diverse residents and respond to clinical challenges. Being engaged in activities that help residents return to their previous level of function or living arrangement also facilitates the development of valuable problem-solving skills.

In an effort to help to ensure the development of a high-quality geriatric workforce, APTA recommends that CMS institute a mechanism by which it designates students’ minutes as “student,” such that they are extrapolated from the total concurrent and group therapy minutes. Implementing a limit on concurrent therapy (and group) without a policy that differentiates between students and therapists and therapist assistants will severely harm the ability 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 health professionals. It also is contrary to the objectives that Senator Susan Collins (R-ME) hopes to achieve through passage of the bipartisan Geriatrics Workforce Improvement Act (S. 2888). This legislation, if enacted, would increase the number of geriatric health professionals, including physical therapists, occupational therapists, and speech-language pathologists, through
improvements in geriatric education for the current workforce while optimizing resources to bolster new academic careers in geriatrics.

**Interrupted Stay Policy**

*APTA Seeks Clarification from CMS on Interrupted Stay Policy*

Within the proposed rule, CMS proposes that if a beneficiary is discharged from a SNF and readmitted to the same SNF within the 3-day interruption window, this would be considered a continuation of the previous stay. The SNF would not conduct a new 5-day assessment and the payment schedule would continue where it left off. The premise for this policy is similar to the End-of Therapy (EOT) Other Medicare Required Assessment (OMRA). When therapy is the primary skill, and the patient misses three consecutive calendar days of therapy, the provider must complete an EOT OMRA, which effectively changes the payment resource utilization group (RUG). In cases where therapy resumes after the EOT-OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level, and with the same therapy plan of care that had been in effect prior to the EOT OMRA, an EOT OMRA with Resumption (EOT-R) may be completed. In these cases, it is left to the clinician’s judgment whether or not a new therapy evaluation should be completed.  

APTA seeks clarification on several points related to the interrupted stay policy. First, does CMS have an expectation that the interrupted stay policy will be operationalized the same way as the EOT and EOT-R? Or, does CMS have an expectation that therapists will always complete a new evaluation upon the beneficiary’s return? As per the current instruction in Section O of the MDS RAI Manual, “If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted.” (MDS 3.0 Chapter 3, Section O, V1.15, page O-19). If an evaluation is performed, will CMS require SNFs to indicate on the claim form that a beneficiary has returned and an evaluation was completed? We urge CMS to clarify its position on this issue, as CMS’s expectations regarding an interrupted stay could have serious implications for the delivery of therapy services, including the cost of those services, particularly for beneficiaries discharged after Day 20 and who return within a 3-day window.

Second, when a beneficiary is discharged from the facility, does CMS expect SNFs to wait to see if the beneficiary returns before completing the discharge assessment? If the beneficiary does not return within the 3-day window, then what are the implications for setting the Assessment Reference Date approximately 4 to 5 days after discharge? As currently defined, this would be considered a late assessment, and could subject the SNF to penalties. If it is required, then this adds to the administrative burden, which is contradictory to CMS’s stated goals.

Third, when a SNF completes a Discharge Assessment, and the resident’s stay included one or more interrupted stays, how would the SNF count the total volume, mode, and type of therapy to report in Section O? Would they count it from Day 1, the original admission date, even though there was an interrupted stay (and potentially a previous discharge assessment completed), or

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would this discharge assessment only include the volume, mode, and type of therapy delivered since the time of return to discharge?

Lastly, the interrupted stay policy seems to unfairly penalize both beneficiaries and SNF providers. Under the current SNF PPS, the day of discharge from the SNF is not paid, and it is not counted against the beneficiary’s 100-day benefit period. Under the proposed PDPM, if a beneficiary is discharged and returns within the 3-day interruption window, then:

- Day 7 is counted as a ‘day’ in the beneficiary’s benefit period, and the day of readmission is counted as Day 8. Under the current PPS, the day of discharge does not count as a “day” in the beneficiary’s benefit period.
- The day of discharge, Day 7, is a non-billable day by the SNF provider, and in this example is one of the 20 PT/OT days paid at 100 percent of the case-mix.
- As a result of “Day 7” counting against the beneficiary’s 100-day benefit period, the SNF provider effectively only has 19 days of a PT/OT category paid at 100 percent of the case-mix.

APTA urges CMS to clarify within final rulemaking its expectations regarding the interrupted stay policy, particularly in relation to the completion of therapy-related evaluations and discharge assessments.

**Potential Impacts of Implementing PDPM**

*Budget-Neutral Implementation*

CMS proposes to implement the PDPM in a budget-neutral manner because the agency does not intend to change the aggregate amount of Medicare payments to SNFs. The most significant shift in Medicare payments created by implementation of the proposed PDPM would be from facilities with a high proportion of rehabilitation residents (particularly facilities with high proportions of Ultra-High Rehabilitation residents) to facilities with high proportions of non-rehabilitation residents. Other facility types that may see higher relative payments under the proposed PDPM are small facilities, non-profit facilities, government-owned facilities, and hospital-based swing-bed units.

A new case-mix system will require providers to make a significant, time-intensive investment in training clinical and administrative staff. Additionally, SNFs will likely need to purchase new hardware and software to update their electronic health records module in order to operationalize the new payment system. By implementing the PDPM in a budget-neutral manner, CMS will help to ensure its efforts to update the payment methodology do not obstruct the ability of SNFs to deliver high-quality, timely, cost-effective care to their patients, including those higher complexity SNF patients who require substantial resources. APTA supports CMS’s proposal to implement the PDPM in a budget-neutral manner.

*Ensure PDPM Base Rate Accuracy*

Given CMS’s proposal to implement the PDPM in a budget-neutral manner, APTA requests CMS clarify its intention to distribute the therapy non-case-mix rate among the therapy components due to a discrepancy between the proposed rule and Acumen’s technical report. Within the rule, CMS proposes to separate the “therapy case-mix” rate component into a “PT”
component, “OT “component, and a “SLP” component. CMS also proposes to separate the “nursing case-mix” rate component into a “nursing” component and a “NTA” component. The agency further states in the proposed rule that because all “SNF residents under PDPM would be assigned to a classification group for each of the three proposed therapy-related case-mix adjusted components as further discussed below, we propose eliminating the “therapy non-case-mix” rate component under PDPM and distributing the dollars associated with this current rate component amongst the proposed PDPM therapy components. The existing non-case-mix component would be maintained as it is currently constituted under the existing SNF PPS.”

While we understand and support CMS’s rationale to distribute the dollars associated with the therapy non-case-mix rate among the therapy components, this assertion is not reflected within Acumen’s technical report. As illustrated in Tables 63 and 64 within Acumen’s technical report, it is apparent that the therapy non-case-mix in the “Actual RUG-IV FY 2017 Base Rates” table fails to crosswalk to the therapy component rates within the “Estimated PDPM FY 2017 Base Rates” table. Therefore, APTA requests CMS clarify within the final rule its intention regarding the therapy non-case-mix rate, as it is critical to ensure the total base rates under RUG-IV match the new base rates under the proposed PDM to ensure SNFs receive adequate reimbursement and budget-neutrality is maintained.

**CMS Must Recalibrate Case-Mix Weights and Monitor Per Diem Adjustment Schedule**

As previously recommended, we encourage CMS to adopt a streamlined checklist approach for categorizing patients into clinical categories within the PDPM components. This approach will assist CMS in data collection and also help the agency recalibrate the PDPM’s case-mix weights in future years based upon SNF data. To that end, APTA strongly encourages CMS to formalize a transparent process and timeline to refine the PT and OT component case-mix determinations soon after implementation of the PDPM, to assess whether various factors will influence the ability of the model to better predict PT and OT resource use, including new Section GG items that are being introduced October 2018, indicators of current cognitive impairment including those being developed under the SNF QRP, and potential comorbidities related to PT and OT utilization. It is imperative that the case-mix weights reflect current care protocols and resource needs and include details of this plan within final rulemaking. Further, we recommend that CMS continue to examine the per diem adjustment schedule and evaluate whether modifications may be necessary in the future to ensure appropriate care delivery.

**Assistance for Providers**

*Provide Ongoing, Continuous Training to SNF Clinicians and Staff*

Implementation of the PDPM as currently proposed will require SNFs to hire more staff and offer significantly more training. Any savings that CMS has estimated will be achieved by the reduction in burdens associated with the PDPM will be negated, given that the SNF will need more skilled MDS coordinators, billing, and coding staff who also will require additional

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training. Therefore, if CMS moves forward with the ICD-10 clinical categorization approach, we request that CMS offer free or subsidized ICD-10-CM and ICD-10-PCS training for SNF clinicians and staff in an effort to offset the costs SNFs will need to expend to prepare for adoption of the PDPM.

**Other APTA Recommendations**

*Adopt an Outlier Payment System*

APTA recommends that CMS consider incorporating an outlier payment system within the PDPM, effective October 1, 2019, as a means to reimburse SNFs for residents whose costs far exceed the costs of typical patients, similar to other settings, including acute care hospitals and home health agencies. As support for adopting an outlier policy, we point to the MedPAC March 2018 Report to Congress, in which MedPAC states that since 2008, the Commission has recommended revising the SNF PPS to base therapy payments on patient characteristics (not service provision), removing payments for NTA services from the nursing component, establishing a separate component within the PPS that adjusts payments for NTA services, and implementing an outlier payment policy (MedPAC 2008). Each year since then, the Commission has urged CMS to move forward with reforms to the SNF payment system. Given that many of the PDPM’s features mirror that of MedPAC’s previous recommendations, we believe adopting an outlier policy for SNFs is justifiable. As MedPAC stated in its March 2016 Report to Congress, “An outlier policy would offer some financial protection by partly compensating providers that treat exceptionally costly patients. An outlier case would be defined on a stay basis, not on a day basis, because the financial risk to a facility is determined by its losses over the stay, not a given day.”

Incorporating this recommended outlier policy will help to ensure providers are not dis-incentivized to deliver care to some of the most vulnerable patient populations.

*Request for Clarification on Compliance with Medicare/Medicaid Requirements of Participation*

Finally, APTA requests that CMS clarify within final rulemaking how SNFs are expected to comply with the Medicare and Medicaid Requirements of Participation and whether SNFs will continue to be required to complete the Omnibus Budget Reconciliation Act- required discharge assessments, as well as the EOT- related assessments. Also, we encourage CMS to clarify how a SNF may comply with the coverage requirement to provide skilled services on a daily basis in instances when skilled rehabilitative services are halted—but intended to resume—due to a resident’s illness or procedure, and the only skilled service required is rehabilitation services. In these instances, a resident’s coverage could be jeopardized if therapy was the only skilled discipline, but those services had to be held for medical reasons.

**SNF QRP**

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

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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.

**Accounting for Social Risk Factors**
APTA recognizes that adjusting for social risk factors in certain outcome measures is a complex issue. We appreciate 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 publicly reported outcome measures can be misleading to consumers.

APTA supports the overarching strategies outlined in the Office of the Assistant Secretary for Planning and Evaluation (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. We support CMS’s discussion to consider options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures; additionally, we support CMS’s efforts to consider options to address equity and disparities in its VBP programs. APTA is pleased that CMS will continue to work with ASPE, the public, and other stakeholders to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences. 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.

**Proposed New Measure Removal Factor for Previously Adopted SNF QRP Measures**
CMS proposes to adopt an additional factor to consider when evaluating potential measures for removal from the SNF QRP measure set: Factor 8. *The costs associated with a measure outweigh the benefit of its continued use in the program.* APTA supports the addition of this measure removal factor for previously adopted QRP measures, on a case-by-case basis. We agree with CMS’s assertion that when the costs outweigh the evidence supporting the continued use of a measure in the SNF QRP, it may be appropriate to remove the measure from the program.

**Proposed Policies Regarding Public Display for the SNF QRP**
CMS proposes to increase the measure calculation and public display periods from 1 to 2 years of data to increase the number of SNFs with enough data adequate for public reporting for Medicare Spending Per Beneficiary QRP measure and the Discharge to Community QRP measure. CMS also proposes to begin publicly displaying data in Calendar Year 2020, or as soon thereafter as is operationally feasible, on 4 assessment-based measures. APTA supports these proposals.
**SNF VBP Program**

The measure adopted for the SNF VBP Program currently includes the SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510). However, CMS intends to use the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR) in place of the SNFRM as soon as practicable, as required by statute. APTA recognizes that the agency may intend to rely on the SNF VBP Program, in addition to others, as one of the mechanisms to ensure beneficiary access is not restricted and providers maintain compliance with Medicare regulatory requirements and guidelines under the proposed PDPM. However, evaluating the impact of PDPM implementation on therapy service delivery patterns must be done so using quality and outcomes measures that are commonly associated with effective rehabilitation services. For the VBP program to be a valid mechanism by which the agency can monitor and regulate provider behavior in the future, we recommend the agency incorporate more robust patient-outcome measures, such as total change in activities of daily living (ADL) performance by SNF patients or a composite functional decline measure.

**Interoperability RFI**

APTA appreciates the opportunity to provide feedback in response to CMS’s RFI on interoperability. After careful consideration, we offer the following suggestions:

1. **If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?**

   APTA believes that the proposed standards to require the electronic exchange of patient medical records would help to prevent information blocking by providers and ensure patient access to their records and the sharing of information with other providers. However, the proposed policies fail to create the same obligations for EHR vendors to ensure vendors make patient information readily accessible by patients and providers. This unbalanced treatment of health care providers and EHR vendors can make it difficult, if not impossible, for providers to satisfy the proposed requirements to increase interoperability.

   APTA supports CMS’s proposals to ensure providers make health information accessible to patients and other providers. However, we recommend that the agency, along with the Office of the National Coordinator (ONC), explore similar standards for EHR vendors as conditions for their certification. We also encourage CMS and ONC to update EHR certification criteria to require EHR vendors to attest that they will not interfere with the exchange of patient data between providers and patients and they will address in a timely manner complaints from providers and patients regarding the exchange of and access to patient data.

2. **Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through**
existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

Rather than revise the existing CoPs, we recommend that CMS require acute care hospitals to comply with the QRP requirements of the IMPACT Act, along with the applicable penalties for failure to comply. Doing so would extend the current interoperability steps seen in post-acute settings across the entire continuum of care. At the same time, a hospital would not ‘lose’ the ‘right’ to accept patients (not a CoP) and would still suffer penalties for not sharing this information across the continuum. It is important to note that hospitals and ambulatory doctors have received meaningful use dollars that were not provided to post-acute care settings. Even so, post-acute settings are now required to increase interoperability via the IMPACT Act, whereas hospitals and ambulatory clinics are not identified in the IMPACT Act. In essence, there are unfunded mandates placed on post-acute settings. Even so, the greatest transition of care ‘risk’ is from the acute hospital setting to any other setting. Post-acute providers have EHRs which are capable of receiving data; however, it is ‘difficult’ for hospitals to share the data. While we disagree with the idea of mandating interoperability via the CoPs, we agree that CMS should put forth a policy to incentivize this data transaction, with no cost to post-acute providers.

With that said, we have concerns as to whether this would benefit or harm private physical therapy practices. For instance, the physical therapy practice could be pressured by the hospital to become part of the health information exchange if the practice wants access to the data. However, the fees to join the health information exchange could be too high for the private practice; hence, the private practice could be faulted for blocking information sharing, due to circumstances outside of their control.

Moreover, we recommend harmonization of data elements across all settings with the ability to capture the functional status of the patient and the outcome based on the care provided. We believe hospitals and other providers should be able to share information on the patient’s goals and preferences and on preparing patients and, as appropriate, their caregivers/support person(s) to be active partners in their post-discharge care. This would help to ensure effective patient transitions from hospital to post-acute care while planning for post-discharge care that is consistent with the patient’s goals of care and treatment preferences, as well as reduce the likelihood of hospital readmissions.

We recommend CMS create standardized data elements for discharge and transfer that incorporate information regarding functional status across settings. The patient’s ability to function and participate in society is critical to obtaining positive outcomes. A growing percentage of the U.S. population has disabling conditions that limit their ability to carry out the major activities of their age group. As the number of older adults increases, their vulnerability to injury and limitations of their activities of daily living increases as well. This increase in vulnerability and decreased function results in an escalation of the utilization of health care resources. A focus on ensuring that individuals remain independent and functioning members of society throughout their lives will lessen the burden of disability on health care resources.
3. **Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?**

Depending on the timeframe for implementation, the use of non-electronic forms should be permitted. We suggest that CMS offer a transitional timeline to allow providers adequate time to implement and adopt interoperability. As CMS implements new and revised CoPs, we also recommend the agency consider the variety of care settings in which interoperability will be adopted, as this type of mandate could negatively impact providers that are rural and lack internet connectivity. For example, some rural providers utilize a satellite dish for their internet connectivity and the speeds are not fast enough to support EHR systems; further, the cost to acquire a cable connection can be more than $50,000 due to the providers’ geographic location. Other providers, such as physical therapists, will also require a transition timeline to obtain and integrate EHR technology for their practices.

4. **What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?**

APTA recommends that CMS afford small and rural practitioners and practices an exception to the interoperability and health information exchange requirements. Providers and practices in rural areas often experience difficulties in acquiring the necessary technology to support EHR systems at a reasonable cost. We do recognize, however that CMS’s goal is to encourage as many providers as possible to improve interoperability across care settings. To incentivize more providers beyond hospitals and post-acute care facilities to satisfy the interoperability and health information exchange requirements, we recommend that CMS offer financial incentives to these providers who would suffer a financial hardship to comply with the new standards.

5. **We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records.**

While APTA supports CMS efforts to increase patient access to their health data, we also have concerns that increasing access simultaneously increases the risk of unwanted disclosure of that health data. We therefore encourage CMS to implement increased
safeguards to prevent data breaches and educate patients on protecting the privacy of their health data.

6. **To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public’s ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers.**

APTA recommends that CMS describe in detail what is intended to mean “fully interoperable health IT and EHR systems for Medicare.” We encourage the agency to ensure that all patient health data be stored and accessed from one single database, to avoid inconsistencies that may occur with multiple databases of patient information. Further, we recommend that the IT and EHR system include secure verification processes and systems to verify providers and patients who wish to retrieve patient data. Finally, we recommend that the agency work with state Medicaid agencies to resolve any barriers that exist for the sharing of health data across state lines. We support the move to a fully interoperable health system, however, many federal and state regulatory barriers will first need to be addressed to allow for data between states, providers, patients, and their families.

7. **We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.**

Physical therapists and physical therapy practices are a critical component of the medical network across the care continuum. To date, physical therapists in private practice have not formally been included in the meaningful use/promoting interoperability program and our facility-based providers are not as exposed to these regulations in the facility setting. Our comments reflect the issues we have identified as a profession with respect to IT adoption and interoperability. Hence, physical therapists may need additional time to obtain EHR systems and the technical and financial capacity to collect and share electronic health care data. APTA encourages CMS to address the health IT adoption and interoperability needs of physical therapists and physical therapy practices as the agency moves to adopt the new and revised standards. We urge the agency to consider financial
incentives to alleviate the costs that physical therapists will no doubt face in complying with new interoperability requirements. We look forward to more opportunities to work with CMS to address solutions to alleviate the burden on specialty providers who have not yet been included in previous EHR incentive programs.

**Conclusion**

We thank CMS for the opportunity to comment on the FY 2019 SNF PPS, VBP, and QRP proposed rule. APTA is eager to engage in meaningful dialogue and work with the agency in developing a payment model 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