June 30, 2009

Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1410-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

RE: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010 Proposed Rule; Minimum Data Set, Version 3.0 (CMS-1410-P)

Comments submitted via electronic submission

Dear Ms. Frizzera:

On behalf of the American Physical Therapy Association’s (APTA) 73,000 member physical therapists, physical therapist assistants, and students of physical therapy, I thank you for the opportunity to submit comments regarding the Skilled Nursing Facility (SNF) Fiscal Year (FY) 2010 proposed rule. On May 12, 2009, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule that contains several revisions regarding the payment structure, refinement of case-mix classifications, and changes to the Minimum Data Set (version 3.0) as they relate to the SNF Prospective Payment System. Physical therapy is an integral service provided to Medicare beneficiaries in the skilled nursing facility setting, and therefore we are very concerned about the impact that proposed revisions included in the rule would have on the provision of physical therapy services in the SNF setting.

We commend CMS on its efforts to expand the RUG IV classifications that account for the relative resource utilization of different case mix groups. Specifically, CMS proposes to modify the eight levels of the hierarchy and increase the number of case-mix groups from 53 to 66. We believe that this change is a step in the right direction and will allow SNFs, as well as physical therapists, to more accurately define and document the patient’s needs and resources thus improving the quality of care. We encourage CMS’ continued efforts in this area, and we have some specific recommendations (addressed below) that we believe will aid CMS in improving its current proposal.

In addition, we are also pleased that CMS acknowledges the current work that is being conducted in concert with SNF PPS revisions to reform Medicare post-acute care payment,
such as the alternatives to the Inpatient Rehabilitation Facility (IRF) “75 Percent rule” and the Post-Acute Payment Reform Demonstration. Specifically, CMS states:

“In considering changes to the classification system, we considered alternative models. Since the inception of the SNF PPS, we have investigated ways of developing a predictive model for therapy that could replace the existing methodology. During the demonstration that led to the development of the SNF PPS, we considered a therapy model based on need. However, there was a great deal of concern that by separating payment from the actual provision of services, the system, and more importantly, the beneficiaries would be vulnerable to underutilization…

While we will continue to study this model, we believe it would be premature to include it in the RUG-IV model being proposed in this rule for two reasons.

First, in accordance with section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, Pub. L. 110-173), the Congress has asked us to look at alternatives to a diagnosis-based model for evaluating facility compliance under the IRF PPS. During the past 3 months, we have spoken with a large number of clinicians and other stakeholders who have expressed strong reservations about using diagnosis as a predictor of therapy need. We have contracted with the Research Triangle, Inc. (RTI) to investigate alternatives, and want to review the results of this research before proceeding with a diagnosis-linked model for therapy in SNFs.

Second, we are working closely with CMS staff on the Post Acute Care (PAC) Payment Reform demonstration project. Data are currently being collected from SNFs, IRFs, home health agencies, and long-term care hospitals that we believe will help us predict the need for post-hospital care across these four settings. We believe that the results of the PAC Payment Reform demonstration project will assist us in developing a more effective model for therapy reimbursement.

*We believe that significant changes in the SNF PPS therapy payment model would be most appropriately considered after the conclusion of research on diagnosis-based models and the PAC demonstration described above.*

APTA strongly agrees with this statement. We believe that it is imperative that Medicare initiatives and projects are not carried out in isolation but rather performed in a comprehensive and inclusive manner that fully assesses the totality of their impact on the entire Medicare program. The work being conducted in the Post-Acute Care Payment Reform Demonstration and the alternatives to the IRF “75 Percent Rule” is critical to ensuring that payment systems and polices are organized around the individual’s need, rather than around the settings where care is delivered. A beneficiary-centered system for delivery of services has the potential to improve quality of care and continuity of care. APTA has been very
involved in each of these projects, and we are committed to aiding the Agency in its endeavor to accurately assess Medicare beneficiaries and ensure that they receive the optimal post-acute care that best fits their condition.

APTA would also like to commend CMS on its proposed change to the Other Medicare Required Assessment (OMRA) including the significant change time points for collecting data. We believe that this proposed change will result in the appropriate placement of patients into the proper RUGs group and more accurately reflect the resources associated with providing services to the patient.

In addition to the above mentioned provisions of the proposed rule, we are concerned about the impact of several other provisions included in the rule. Our comments articulated below address those specific provisions with our recommendations on how these policies can be further refined.

Methodology of the Staff, Time, Resource Intensity Verification (STRIVE) Project (74 FR 22220)

Two-hundred and five nursing homes from 15 states and jurisdictions participated in the Staff, Time, Resource Intensity Verification (STRIVE) project; with the primary objective of identifying the level of staff resources needed to provide quality care to nursing home patients. Participating facilities submitted both time and MDS assessment data. The proposed rule states that therapy staff, including physical therapists and aides, occupational therapists and aides, and speech-language pathologists, recorded time over 7 consecutive days.

APTA noticed that the proposed rule does not list physical therapist assistants as a SNF staff participant in the STRIVE project. It is our understanding, after review of the STRIVE data and discussions with CMS staff, that physical therapist assistants were included in the data collection efforts of the STRIVE project. Therefore, we believe that this is an oversight by the Agency and request that CMS include a clarification in the final rule confirming the inclusion of physical therapist assistants in the STRIVE project.

Another area of concern is the sampling method employed by the STRIVE project. According to the STRIVE analyses, the RUG-III model is still effective in determining relative nursing resource use across a broad range of conditions. However, CMS found that the resource times associated with specific conditions or services categories (i.e. diabetes and use of intravenous fluids and medications) has changed significantly. Therefore, CMS concluded that the RUG-III model needs to be updated to reflect significant changes in SNF care patterns during the past 10 years.

While we wholeheartedly support the Agency’s efforts to collect and aggregate the most recent data in order to update payments for Medicare SNFs and Medicaid nursing facilities, we also believe that data should be collected in an all-inclusive and meticulous manner that represents the complete assessment of care furnished in the SNF setting. We are seriously
concerned about the minimal number of nursing homes and states that were represented in the STRIVE project.

It is our belief that from this small sample collected over only a 7 day period using the paper tool and only three days using PDAs for therapy, it is impossible to obtain a complete and accurate picture of the care delivered in the SNF setting and furthermore, properly define how that care should translate to the SNF PPS. We contend that the STRIVE methodology is based on a large number of assumptions regarding facility practices and reaches several conclusions that we believe are seriously flawed. Therefore, we strongly urge CMS to conduct a more in-depth analysis of SNF data before implementing changes based on the STRIVE data that will have major impacts on Medicare SNFs and Medicaid nursing facilities for potentially the next decade.

We appreciate CMS’ progress of collecting significantly more data than that gathered in the 1994 sample used initially to develop RUG-III, and the 1995/1997 sample used to revise RUG-III and establish the current CMIs that are the basis for current Medicare rates. However, we still are not wholly convinced that the data collection methods of the STRIVE project were exhaustive enough to obtain the requisite data necessary to make the appropriate changes to the RUG classifications, MDS, or therapy payment models. The issues and complexities of the SNF PPS have significantly evolved over the past 15 years, and we believe that CMS should conduct the proper data collection efforts to accurately assess the current environment of SNFs under the Medicare program.

**Calculation and Documentation of Concurrent Therapy (74 FR 22222)**

In the proposed rule, CMS expresses its belief that there has been a shift from one-on-one therapy to concurrent therapy and contemplates whether this practice should be limited. Concurrent therapy is the practice of the therapist treating multiple patients at the same time while the patients are performing different activities. In SNF Part A, concurrent therapy is distinct from group therapy, where one therapist provides the same services to everyone within the group. Currently, there are no restrictions regarding the number of patients that can be treated concurrently or the amount/percentage of concurrent therapy time that can be included on the MDS. CMS is concerned that concurrent therapy has become a standard of practice rather than a way to supplement needed individual care. According to STRIVE data, approximately two-thirds of all Part A therapy provided in SNFs is now being delivered on a concurrent rather than individual basis. Furthermore, CMS is concerned that the current method for reporting concurrent therapy on the MDS creates an inappropriate payment incentive to perform concurrent therapy in place of individual therapy.

Additionally, CMS believes that STRIVE data showed that patients treated concurrently are assigned to higher therapy groups with higher payments when in fact other classifications may have been appropriate. In order to mitigate these perceived abuses and to reinforce that individual therapy is the optimal mode of delivery, CMS proposes to use allocated concurrent therapy minutes in developing the RUG-IV therapy model.
Therefore, the Agency poses the following questions to stakeholders:

1) whether it will be sufficient to include a record of therapy usage by therapy mode in the medical record; and
2) whether there should be other restrictions relating to concurrent therapy such as a limit to the percentage of concurrent therapy minutes that may be counted on the MDS for any individual or to the number of people that can be treated concurrently by the same therapist.

First, we agree with CMS’ statement that:

“In the SNF Part A setting, concurrent therapy can be a legitimate mode of delivering therapy services when used properly based on individual care needs as determined by the therapist’s professional judgment. We believe it is in the beneficiary’s best interest that concurrent therapy should never be the sole mode of delivering therapy care to any individual in a SNF setting; rather, it should be used as an adjunct to individual therapy when clinically appropriate, as determined by the individual’s current medical and physical status based on a therapist’s clinical judgment.”

Secondly, although, APTA believes that concurrent therapy should not be the predominant mode of therapy, we do believe that concurrent therapy, as described by CMS in this rule, would meet the definition of skilled therapy services under Medicare’s coverage guidelines.

Medicare sets forth its definition of skilled physical therapy services in § 30.4.1.1 of Chapter 8 of the Medicare Benefits Policy Manual in which they require that the following conditions be met:

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;
- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge and skills of the qualified physical therapist;
- The services must be provided with the expectation, based on the assessment made by the physician of the patient’s restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;
• The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient’s condition; and,
• The services must be reasonable and necessary for the treatment of the patient’s condition; this includes the requirement that the amount frequency and duration of the services must be reasonable.

These requirements do not delineate whether services provided individually, concurrently, or in a group have any bearing on the determination of whether those services are skilled therapy services. In the alternative, the nature of the services relates to the skill and complexity associated with the treatment procedures the therapist uses and the professional judgment of the physical therapist, not the therapy mode in which the therapist chooses to apply these treatment procedures. Concurrent and individual therapy are appropriate modes of therapy delivery when they meet the criteria outlined in § 30.4.1.1 of Chapter 8 of the Medicare Benefits Policy Manual.

Thirdly, it may be advantageous for the therapist to work with a select number of patients concurrently for the support, motivation or modeling. For example, a physical therapist may have one patient with an amputation performing prescribed and previously instructed therapeutic exercises on a mat to increase the strength of the remaining lower extremity muscles. This patient is also practicing wrapping of the residual limb to decrease edema; the patient remains in the physical therapist’s line of sight to ensure proper technique. The second patient with left sided weakness is performing dynamic balance re-training in the parallel bars with the physical therapist challenging postural stability.

With the first patient, the physical therapist is ensuring independence in the program in preparation for the patient’s discharge home. In the second example, the complexity of the patient’s condition requires the therapist’s judgment and clinical decision making to design, implement, monitor, and adjust the treatment plan. Both patients are providing each other support and motivation as they both work toward common goals.

Thus, physical therapists working in SNFs should be able to use a combination of individual, concurrent and group therapy as medically necessary in accordance with Medicare coverage guidelines for skilled therapy. We believe that the use of all three modes (individual, concurrent and group) can reflect optimal care for patients within the SNF setting. CMS should rely on the professional judgment of the therapists to decide which modes of therapy are appropriate to treat their patients. It is the responsibility of the therapist to make judgments that are in the best clinical interests of the patient.

Fourth, we recommend that concurrent therapy should consist of no more than two patients per therapist during any one treatment session conducted within the SNF. We believe that any treatment that involves three or more patients per therapist should be classified and documented by the therapist as group therapy. We believe that such a policy will allow the therapist the flexibility to treat more than one patient within a single treatment session while also ensuring that the patient is receiving skilled therapy specially designed to treat their specific condition. In addition, concurrent therapy should not represent the predominant
portion of therapy minutes recorded on the MDS. Setting forth a policy that recognizes the value of concurrent therapy, while also specifying that concurrent therapy should not constitute the majority of therapy minutes reported on the MDS, will address concerns regarding the potential overutilization of concurrent therapy while allowing therapists to provide skilled therapy services based on their clinical judgment.

Lastly, APTA suggests that CMS utilize other established venues to address abuses or fraudulent activities regarding concurrent therapy or any other activities. We believe that these activities should be referred to the Department of Health and Human Services (HHS) Office of the Inspector (OIG) for proper adjudication and prosecution. This is the best venue in which to address the alleged abuses regarding the use of concurrent therapy discussed by CMS in this proposed rule.

Organizing the Nursing and Therapy Minutes (74 FR 22228)

In the proposed rule, CMS provides an extensive discussion regarding the updates to nursing and therapy minutes used to determine the case-mix indexes for each group. Each RUG-IV group would be assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the patients in each group. According to CMS, the updated index scores would be based on the amount of staff time, weighted by salary levels. In order to calculate the CMIs for each group, CMS obtained salaries for different kinds of staff positions from the 2006 Department of Labor Occupational Employment Statistics survey. The agency then computed the ratio of median salaries for nursing and therapy staff to the median salary of a certified nurse aide. CMS used the CNA wage rate as the base in establishing wage-weighted staffing time (WWST) ratios for other health care professionals because CNAs generally provide the most minutes of care.

Specifically, CMS states that:

“We collected measures of the staff time required to care for nursing home patients and used them to identify specific clinical characteristics that are predictive of patient resource use. In order to do this, we combined and analyzed characteristics of the patients in the STRIVE study and the time it took to care for them. We then used these analyses to identify the patient characteristics that best explain weighted patient-specific time. From this, we created the 66 RUG-IV groups and calculated separate nursing and rehabilitation therapy case-mix indexes for each group. In determining the case-mix indexes for each group, we first obtained the salaries of all staff types from the 2006 U.S. Department of Labor, Bureau of Labor Statistics Occupational Employment Statistics survey. Next, we computed the ratio of median salaries for different nursing and rehabilitation therapy staff to the median salary of a certified nurse aide. These ratios were used as the salary weights for each staff category. The basic calculation performed for each patient was to take the minutes spent providing patient care and multiply them by the weight that represents the staff person's salary. Thus, we multiplied the
registered nurse's minutes by 2.58, the licensed practical nurse's minutes by 1.65 and the aide's minutes by 0.85, 1.0, or 1.20 (depending on the specific aide's job title) and then summed to yield salary-weighted nursing time for the patient.

For therapy, we multiplied the physical therapist's time by 2.98, the occupational therapist's time by 2.72, the speech pathologist's time by 2.60, the licensed physical therapy assistant's time by 1.86, the licensed occupational therapy assistant's time by 1.90, and the therapy aide's time by 0.99 (physical therapy aide), 1.13 (occupational therapy aide), or 1.06 (therapy aide or therapy transport aide) and then summed to yield salary-weighted therapy time for the patient. We then averaged the salary-weighted nursing time for each group to yield an array of 66 nursing case-mix index scores and averaged the salary-weighted therapy time for the five different levels of therapy (Ultra High, Very High, High, Medium, and Low) to yield therapy case-mix indexes for those levels. These indexes comprise the unadjusted nursing and therapy weights for RUG-IV.

Our intent in implementing RUG-IV is to allocate payments more accurately based on current medical practice and updated staff resource data obtained during the STRIVE study, and not to decrease or increase overall expenditures. Thus, consistent with the policy in place when we transitioned to the RUG-III 53-group model in FY 2006 (as discussed in section II.B.2), we believe that overall expenditures under the RUG-IV model should maintain parity with overall expenditures under the RUG-III 53-group model. Therefore, we simulated payments under the RUG-III 53-group model and the RUG-IV 66-group model to ensure that the change in classification systems did not result in greater or lesser aggregate payments.”

APTA contends that this methodology is seriously flawed and therefore, the case mix indices for the therapy groups are not accurate. To determine the case mix indices, CMS used salary data from the 2006 U.S. Department of Labor, Bureau of Labor Statistics Occupational Employment Statistics survey. The salary data derived from the BLS survey in 2006 does not accurately reflect the salaries of physical therapists and physical therapist assistants. The salary data issued by BLS is significantly lower than data derived by APTA in a Practice Profile Survey that is conducted each year on salaries in the SNF setting. The difference in APTA’s salary projections and BLS’ data is likely due to the fact that respondents to the BLS survey select their occupation when, in reality, they are not members of the specific occupation.

For example, it is likely that individuals who provide services similar to physical therapy, such as massage therapists, include themselves in the physical therapist category. Unfortunately, the generic term “physical therapy” is confounded with those respondents who are not licensed physical therapists. Since those individuals using the generic term to describe themselves typically earn less, the salaries of physical therapists are reported as lower than
they actually are. The higher salaries reported by APTA have been validated through evidence provided by individuals with hiring responsibilities in SNFs. Since recruitment of physical therapists in this setting has been difficult, salaries have been increased in hopes of higher pay becoming an incentive for a physical therapist to take a position in a skilled nursing facility. These conversations support APTA’s data and contradict that which is reported by the BLS. In addition, the salaries of physical therapists increased significantly between 2006 and 2008 and therefore the 2006 salaries would not accurately reflect the current salaries.

The 2009 Practice Profile Survey represents the most recent of a series of data collection efforts conducted by the APTA to elicit information from its members on a number of issues that are important to the profession and external stakeholders. The 2009 Median Income of Physical Therapists Summary Report particularly focused on salary data from the five most recent surveys, representing calendar years 2002, 2004, 2005, 2006, and 2008.

The figures and tables present salary data for physical therapists by geographic region, employment setting, years of experience, highest earned academic degree, level of professional degree, and sex. Also, the data reflects the median gross earned income reported by respondents who were employed on a full-time basis. Hourly rates of those respondents who are employed on an hourly basis are also discussed. Median, rather than mean, salaries are presented because the mean is not as sensitive to extreme values located on only one tale of a distribution.

The report presents salary using two methods. In addition to reporting income based on current actual dollars, APTA adjusted income figures for inflation using the Consumer Price Index (CPI) – a means of adjusting dollar values that is used by the Bureau of Labor Statistics. The added benefit of reporting adjusted income is that current incomes can be expressed in “real” dollars and an accurate barometer of changes in salaries can be established.

APTA’s data shows that the median gross earned income of the physical therapist actually increased by 40 percent between 2002 and 2008. Additionally, respondents working in SNFs had the highest incomes which averaged $85,000. Furthermore, the recently conducted Vacancy Rate Study indicated that these settings continue to have a difficult time recruiting physical therapists. It would appear that increasing salaries is one strategy used to aid recruitment.

Therefore, we strongly recommend that CMS revisit its proposed indices for therapy minutes based on salary data that more accurately reflects current physical therapist and physical therapist assistant salaries. CMS should not solely base its index scores on information contained within the 2006 U.S. Department of Labor, Bureau of Labor Statistics Occupational Employment Statistics survey. Alternatively, the Agency should consider APTA’s survey data and/or should conduct its own survey that collects data from the SNF setting, exclusively, and accurately reflects the most current salary levels of therapist and therapist assistants in this setting. APTA is more than willing to aid the Agency in this endeavor. As evidenced above,
our Research Department gathers this data on a yearly basis and has the requisite expertise and infrastructure that would prove beneficial to the Agency in their analyses.

**Changes to the MDS (Elimination of §T of the Resident Assessment Instrument (RAI)) (74 FR 22244)**

Currently, a SNF is required to record the rehabilitative therapy services (PT, OT, and SLP) that have been ordered and are scheduled to occur during the early days of the patient’s SNF stay. Section T of the Resident Assessment Instrument (RAI) provides information prospectively on treatments and therapies not reported elsewhere in the patient assessment. CMS states in this proposed rule that the practice of basing payments on services ordered and scheduled, but not yet received, can lead to inaccurate RUG classifications and payment. In response, CMS proposes to eliminate § T of the RAI effective October 2010. While we support the Agency’s efforts to ensure appropriate classification of patients into therapy categories, we do not believe that the elimination of § T is the best approach to achieve this objective. Section T assists the therapist in making clinical projections regarding the amount of care needed which in turn results in better coordination of care.

In addition, we believe that the elimination of § T will have devastating effects on small SNFs, particularly in rural areas that are already struggling with low staffing levels. Small nursing homes may not have part or even full-time rehabilitation staff available to evaluate a patient the day he or she is admitted. In fact, it may be three to four days before a therapist can see the patient. If section T were eliminated, then a nursing home may potentially not get paid for any therapy services provided during the patient’s first 14 days (since the 5 day MDS pays for days one through 14). As a result, the facility loses money even though they are providing a medically necessary service to the patient.

Another example of how § T assists skilled nursing facilities in providing the most appropriate care is when a patient who is very weak, frail, or medically complex is admitted to the facility. It may be inappropriate to begin the therapy program immediately, but the plan of care indicates that rehabilitation should begin on day 4 or 5 and increase intensity as the therapy progresses. In § T is eliminated in this instance, the facility would not receive the appropriate payment for the delivery of therapy even though a Rehab Medium or High RUG is the most appropriate level of care from days 5 through 14. Thus, maintaining § T in the MDS serves a clinically appropriate purpose – it enables providers to make interdisciplinary projections about the care a patient will need even though that level of care may not have been provided yet. As articulated in the previous section, SNFs are currently dealing with significant therapist shortages, and we believe the elimination of § T will only compound this problem, culminating in meaningful deviations in staffing patterns.

Therefore, we strongly recommend that CMS maintain § T of the MDS. We believe that this information is valuable and adds clinical relevance to the therapy services provided to the patient. We believe that the elimination of the section will have a significant adverse impact on the delivery of care and will negatively impact workforce issues.
In conclusion, APTA thanks CMS for the opportunity to comment on the Skilled Nursing Prospective Payment System proposed rule (FY 2010), and we look forward to working with the agency to craft patient-centered payment policies that reflect quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Associate Director of Regulatory Affairs, at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

[Signature]

R. Scott Ward, PT, PhD
President