June 20, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1645-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically

RE: CMS-1645-P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research

Dear Acting Administrator Slavitt:

On behalf of the 93,000 physical therapist, physical therapist assistant, and students of physical therapy members of the American Physical Therapy Association (APTA), I would like to submit the following comments in response to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Fiscal Year (FY) 2017 proposed rule. Physical therapy is an integral service with in the SNF setting, where physical therapists (PTs) furnish medically necessary services to Medicare beneficiaries to improve their overall health and function, and to optimize their quality of life.

The estimated SNF market basket update to payments for FY 2017 is 2.1% after applicable adjustments. Given the robust resources needed to treat this critically complex population of patients, we commend CMS for proposing this increase, and . Therefore, we wholeheartedly support its inclusion in the final rule.

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

SNF Therapy Research Project
CMS announced in the FY 2015 SNF PPS proposed rule that it had contracted with Acumen LLC to identify potential alternatives to payment for therapy services, and has since expanded the scope to examining potential improvements and refinements to the overall SNF PPS. In the second and current phase, CMS has focused on developing the options and performing more comprehensive data analyses. Acumen has hosted 2 technical expert panels (TEPs). Acumen will host a third TEP to bring together the recommendations as well as the analytic work conducted so far in order to outline what could serve as a potential revised SNF PPS payment model. In this FY 2017 proposed rule, CMS requests feedback from stakeholders on the project and encourages ongoing input to Acumen.

APTA believes that therapy frequency and duration should be based solely on the needs of the patient, and any further attempts to curb overutilization using coverage policies based upon the volume of services furnished is a step in the wrong direction. We believe that CMS should start to develop an alternative therapy payment system under the SNF PPS that will recognize the clinical reasoning and decision-making of the therapist’s evaluative process in addition to planned interventions. This payment system should rely on a classification system based on patient characteristics, condition, and complexity, promote the use of an assessment tool and quality measures that have specific applicability to physical therapy services provided in the SNF, and use electronic health records that include specific components for the documentation of therapy services. Participation in national registries to provide essential data to improve the payment model over time is also essential.

In addition, we believe this new payment methodology should be crafted for applicability and possible implementation in the other prospective payment systems such as home health and inpatient rehabilitation. Transitions in care and continuity between Medicare postacute care benefits should allow for seamless delivery of therapy services. Therapists are integral to transitions in care and should be heavily relied on when this aspect of a new therapy payment system is considered. Therefore, although outside of the scope of this request for information, APTA advocates for consistency of a therapy payment model across all postacute care such as home health, inpatient rehabilitation, long-term care, and SNFs, as well as outpatient settings, to ensure optimal continuity of care in the most appropriate setting to treat the complexity and severity of the patient.

Therefore, we strongly urge that this effort toward a new SNF payment model not be done in isolation. Rather, it is imperative that this effort be heavily influenced by the current work that is taking place in light of the Improving Post-Acute Care Transformation Act (IMPACT). IMPACT requires standardization of quality measures as well the design and implementation of a unified postacute care payment system. The provisions of IMPACT have been under way for the past couple of years, and the Medicare Payment Advisory Commission (MedPAC) has started formulating considerations for the unified postacute care payment system. APTA requests that CMS illustrate to stakeholders how the work toward a new SNF payment model feeds into the work of MedPAC and CMS on the IMPACT unified postacute care payment system.
Second, while we appreciate the opportunity to participate on the panel of technical experts mentioned above, we ask that the process allow sufficient time after the TEP to meaningfully incorporate the feedback of the experts into the final SNF alternative payment design.

Last, this new system should enable claims submitted to Medicare to indicate the individual therapist providing the services and give greater accountability to that therapist regarding billing of therapy claims under the SNF PPS that operates within the parameters of the consolidated billing structure.

**SNF Value-Based Purchasing Program (SNF VBP Program)**

Section 3006(a) of the Affordable Care Act required the Secretary to develop a plan to implement a value-based purchasing program under the Medicare program for SNFs (as defined in section 1819(a) of the Act) and to submit that plan to Congress. Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) added new subsections to the Social Security Act (Act), which authorizes establishment of a Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program beginning with FY 2019, under which value-based incentive payments are made to SNFs based on performance.

CMS proposes to adopt the SNF 30-Day Potentially Preventable Readmission Measure, (SNFPPR), as the all-cause, all-condition readmission measure that will be used in the SNF VBP Program. This measure assesses the risk-standardized rate of all-cause, all-condition, potentially preventable inpatient hospital readmissions of Medicare fee-for-service SNF patients within 30 days of discharge from an acute care hospital, critical access hospital (CAH), or psychiatric hospital.

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

APTA supports the proposed adoption of the SNFPPR, as it is consistent with other CMS readmission measures in the postacute care and acute care settings. Reducing acute care hospital readmissions for all SNF patient populations will decrease cost, improve patient safety, and promote the best possible outcomes for these patients. APTA encourages CMS to add additional measures in the future that will round out the VBP profile, including measures that look at resource use and outcomes, including functional outcomes and return to the community following discharge.

**SNF Quality Reporting Program**
The IMPACT Act requires the implementation of a quality reporting program (QRP) for SNFs. Beginning with FY 2018, SNFs that fail to submit required quality data to CMS under the QRP will have their annual updates reduced by 2%.

The IMPACT Act also imposes new data reporting requirements for certain post-acute postacute care (PAC) providers, including SNFs. The Act requires that the Secretary specify quality measures, and resource use and other measures, with respect to certain domains no later than the specified application date that applies to each measure domain and PAC provider setting. Postacute care providers must use risk-adjusted standardized assessment tools that are endorsed by NQF as the data source for quality measures. These standardized assessment tools must be incorporated into existing setting-specific assessment tools (OASIS, IRF-PAI and MDS).

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

- Discharge to Community – Post-Acute Care (PAC) SNF QRP (claims-based)
- Medicare Spending Per Beneficiary (MSPB) – Post-Acute Care (PAC) SNF QRP (claims-based)
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNFs (claims-based)

CMS is also proposing 1 new assessment-based quality measure:

- Drug Regimen Review Conducted With Follow-Up for Identified Issues (assessment-based)

APTA supports the goal of improving the quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice. Furthermore, APTA feels it is essential that we move toward a core set of functional measures to assess patients consistently across the continuum of care. APTA is pleased to see that the proposed measures for SNFs move in that direction in accordance with the IMPACT provisions. However, APTA does have some concerns about these measures.

**Discharge to Community – Post-Acute Care (PAC) SNF QRP (claims-based)**

APTA supports the implementation of a discharge-to-community measure across the care settings. We believe that successful transitions to the community following discharge from postacute care settings will decrease potentially preventable readmissions.

APTA believes that a patient’s level of function impacts their ability to transition successfully back into the community. Recent evidence indicates that patient function is associated with increased risk of 30-day all-cause hospital readmissions; this may be an important factor in preventing readmissions for Medicare seniors that is not currently
accounted for in measure methodologies. APTA was pleased to see “activities of daily living” scores in the home health setting included in the risk-adjustment methodology for the readmissions measures, and we recently commented to encourage the use of patient function in the risk-adjustment methodology for the care setting readmissions measures. We believe that readmissions and discharge to community are closely related measures and that patient function may also be an important risk-adjustment variable for discharge to community.

APTA appreciates that CMS has strict deadlines for the implementation of measures under IMPACT; however, these measures will be new to those in the affected postacute care settings. Therefore, we encourage CMS to provide those settings with access to this data as early as possible so they have time to adequately review and, more important, implement strategies to decrease readmissions where necessary. As many of these settings do not always receive feedback on the readmissions of their patients after discharge, this data will be new to many facilities.

APTA recognizes that the overall goal of IMPACT is for PAC providers to collect and report standardized and interoperable patient assessment data, and quality and resource use measures. We acknowledge that during the initial IMPACT implementation years there will be a transition period that includes the addition of new measures into all of the postacute care settings. We believe that achieving a standardized and interoperable patient assessment data set and stable quality measures as quickly as possible will allow for better cross-setting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT.

**Medicare Spending Per Beneficiary (MSPB) – Post-Acute Care (PAC) SNF QRP (claims-based)**

First, APTA strongly recommends that this work be incorporated into the larger mandate of IMPACT, which mandated the creation of standardized outcome measures across the respective postacute care settings. This step is necessary to ensure that the totality of postacute care is taken into account. It will also help to ensure that all postacute care settings are assessed equally and that patients are not unfairly steered to receive care in one setting over another based on flawed information regarding resource use and costs. One MSPB measure, in isolation with the limitations of claims based data, cannot define postacute care. Therefore, it is imperative that this measure is used in concert with other measures to more fully define the scope of postacute care services. The final MSPB measure should be used to effectively analyze the necessity of postacute care services and not to merely make payment cuts.

Second, APTA supports and advocates for the adoption of a MSPB measure that first compares cost and resource use within each postacute care provider type and not across the different provider types. As evidenced by the PAC-PRD Demonstration Report and
Med PAC studies, there are significant resource variations across the postacute care settings that need to be adequately addressed before cross-setting comparisons can be achieved. Using the MSPB measure within each provider type will enable postacute care settings to test and assess the measure for appropriate refinements, and address issues within the care setting. After this step has been taken, CMS will then have more information with which to appropriately develop and implement a cross-setting MSPB measure in tandem with the development and implementation of a unified postacute care payment system. Therefore, we commend CMS on implementing the specific MSPB-PAC SNF measure.

Third, APTA recommends that resource use and cost for durable medical equipment (DME) be addressed in this measure. APTA is concerned that DME costs could be skewed if a provider has a disproportionate share of a certain patient population. This is particularly true for settings that treat a high volume of patients with obesity, amputations, and CVAs (hemiplegia/paresis). These providers often have higher cost for DME that are outside of their control. If these items are not accurately captured in the risk adjustment of the MSPB measure, APTA is concerned these providers could be unfairly penalized. We are also concerned that providers could be reluctant to treat patients who may be predicted to have higher costs in areas such as DME.

Last, APTA is concerned about the proposed construct of the national median as the benchmark for the MSPB measure. There is great variance in cost across geographic regions due to different practice patterns, community resources, and patient populations. In addition, the effect of Medicare Advantage (MA) plans play a significant role in cost. The Medicare fee-for-service population in geographic regions where MA plans are prevalent may present very differently from the population in regions where MA plans are not as widespread. Therefore, we recommend that CMS employ state or regional benchmarks first to better capture costs before moving to a national benchmark median.

Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNFs (claims-based)

CMS proposes to adopt the SNF 30-Day Potentially Preventable 30-Day Post-Discharge Readmission measure to satisfy sections 1899B(a)(2)(E)(ii) and 1899B(d)(1)(C) of the IMPACT Act. This measure assesses the risk standardized rate of potentially preventable inpatient hospital readmissions of Medicare fee-for-service SNF patients within 30 days of discharge from an acute care hospital, CAH, or psychiatric hospital.

APTA supports the proposed adoption of the Potentially Preventable 30-Day Post-Discharge Readmission measure, as it is consistent with other CMS readmission measures in the postacute care and acute care settings. As mentioned earlier, reducing acute care hospital readmissions for all SNF patient populations will decrease cost, improve patient safety, and promote the best possible outcomes for these patients.
Drug Regimen Review Conducted With Follow-Up for Identified Issues (assessment-based)

Preventing and responding to adverse drug events is critically important, as these events account for significant increases in health services utilization and costs. This proposed measure assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified. APTA supports this measure and requests that CMS provide more in-depth analysis and explanation of what is meant by the term “clinically significant medication issue(s).”

Conclusion

In conclusion, APTA thanks CMS for the opportunity to comment on the Skilled Nursing Prospective Payment System proposed rule (FY 2017), 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 at roshundadrummond-dye@apta.org or 703/706-8547.

Sincerely,

Sharon L. Dunn, PT, PhD
President

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