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June 20, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1645-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850.

**Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research; Proposed Rule**

Dear Mr. Slavitt:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the proposed rule: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research; Proposed Rule that was published in the Federal Register on April 25, 2015. Physical medicine and rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

**IV. Additional Aspects of the SNF PPS**

Although CMS does not specifically address the requirements of Section 42 CFR § 483.40(c), conditions of participation for long term care facilities, several members of the AAPM&R have expressed concerns about the Medicare Administrative Contractors (MACs) interpretation of the section “frequency of physician visits.” Medicare states “The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.” These are bare minimums in terms of what services a long term care facility must provide in order to be paid under the SNF Prospective Payment System. Additionally, the



conditions of participation have no correlation to the medical necessity or appropriateness of direct patient care services for purposes of coverage and payment under the Medicare program.

Physiatrists have expertise in rehabilitation management and work to assure the highest quality of rehabilitative care in the most cost-effective manner so patients will achieve the highest level of functional ability and quality of life. In fact, by virtue of their training, experience and knowledge of rehabilitation, impairment and function physiatrists have the unique qualifications and expertise to be the leader of the SNF rehabilitation team. The physiatrist will not just track the medical status of the patient but will track and document the patient's functional status demonstrating progress toward goals and identifying barriers to reaching functional goals. Physiatrists will also provide medical services such as treatment of spasticity or pain that is limiting functional gains and will make recommendations for further medical evaluation and treatment. When clinically appropriate, physiatrists will also identify and prescribe adaptive or assistive devices for safety and to further facilitate function. In many patients this requires evaluation and management (E/M) services that occur more frequently than once every 30 days for the first 90 days after admission or once every 60 days thereafter."

A physiatrist may follow a patient 2-3 times a week after the initial E/M through discharge. There are some short-term rehab patients where closer follow-up may be warranted, as well as some longer-term rehab patients where weekly (or even less frequent) monitoring of progress will be appropriate. The physiatrist, through detailed assessment, determines the frequency of follow-up and adapts that frequency to the needs of the patient as they proceed through rehab. The physiatrist management of patients in the SNF setting will lead to greater functional gains by the patient, earlier discharge, and cost savings for Medicare.

**AAPM&R urges CMS to instruct the MACs that denying coverage and payment for physician visits to Medicare beneficiaries that occur in a SNF at a frequency greater than one visit per month based on the conditions of participation in Section 483.40, prevents access to the medically necessary rehabilitation care needed by SNF patients and puts additional strain on the health care system by increasing patient length of stay in a SNF.**

## V. Other Issues

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

In the FY 2016 SNF Final Rule CMS began development of the SNF VBP Program. In this Proposed Rule, CMS continues the process, proposing an all condition risk-adjusted potentially preventable hospital readmission measure for SNFs.

#### 2. Measures

*b. Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR)*

In this Proposed Rule, CMS is proposing to specify the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR) as the SNF all-condition risk-adjusted potentially preventable hospital readmission measure. The Academy generally supports the adoption of this measure and separate measures in each post-acute care setting for 30-Day Potentially Preventable Readmission. However, in the future, a uniform measure that assesses potentially preventable readmission post-discharge from the acute care hospital (regardless of which PAC setting the patient is referred to) will become more relevant, as the silos of PAC settings begin to break down, by design from CMS. In addition, this particular SNF-related measure does not align with the separate measure for IRF patients. This nonalignment makes the measures applicable to SNFs out of sync and could lead to confusion and lack of clarity in terms of potentially preventable readmissions.

*3. Performance Standards*

*(b) (1) Proposed Achievement Performance Standard and Benchmark (page 24246)*

For FY 2019, CMS proposes to define the achievement performance standard (“achievement threshold”) for quality measures specified under the SNF VBP program as the 25th percentile of national SNF performance on the quality measure during the applicable baseline period. AAPM&R believes that the 25th percentile is too high of a threshold for the baseline period. **The Academy recommends the adoption of the 15<sup>th</sup> percentile during the applicable baseline period, as this represents an achievable standard of excellence.**

*4. FY 2019 Performance Period and Baseline Period*

*b. Proposed FY 2019 Performance Period*

In this Proposed Rule, CMS is proposing to adopt FY 2017 (January 1, 2017 through December 31, 2017) as the performance period for the FY 2019 SNF VBP Program, with a 90-day run out period immediately thereafter for claims processing. CMS states “our preference is to adopt at least a 12-month period as the performance period, consistent with our view that using a full year’s performance period provides sufficient levels of data accuracy and reliability for scoring SNF performance on the SNFRM and SNFPPR.” AAPM&R supports the adoption of a 12-month performance period. **However, the Academy has reservations about the adoption of FY 2015 claims data as the baseline for calculating performance standards. The Academy believes that in order to effectively plan for a January 1, 2017 performance year beginning, facilities must have adequate time to analyze their baseline**

**information, thus, facilities must receive their 2015 baseline information no later than the fall of 2016.**

### *7. SNF VBP Reporting*

#### *(2) Phase One: Review and Correction of SNFs' Quality Measure Information*

Starting on October 1, 2016, CMS proposes to use one of the four reports each year to provide SNFs an opportunity to review and provide corrections to their data slated for public reporting. CMS proposes that SNFs will have 30 days after posting the feedback report via the QIES system CASPER files, not counting the posting date itself to make any correction requests. However, CMS does not give any specific timeframes for when responses from a correction request will be given back to facilities from CMS. The Academy recommends that CMS be more explicit in terms of the timeframe the Agency has to respond to correction requests, also ensuring that it is timely and before data is publicly reported. The Academy also urges CMS to provide substantial education to facilities on how correction requests may be submitted, through MLN articles, webinars, briefings, and etc., as necessary.

### **B. Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)**

In this proposed rule, CMS introduces four new quality and resource use measures for SNFs, in accordance with the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014; drug regimen review, average cost per Medicare beneficiary, rehospitalization rate, and discharge to community rate.

#### *6. SNF QRP Quality, Resource Use and Other Measures for FY 2018 Payment Determinations and Subsequent Years*

Although CMS recognizes the important role that sociodemographic status plays in the care of patients, the Agency continues to have concerns that risk adjusting for sociodemographic status holds providers to different standards for the outcomes of their patients of diverse sociodemographic status. CMS also states “we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations.” AAPM&R believes that the scientific literature contains many examples of sociodemographic factors that directly contribute to the development of disease and the validity of the utilization of this information to risk-adjust. The AAPM&R strongly believes that measures should include sociodemographic factors such as socioeconomic status of the individual/family and the resources available in the community in which the patient resides. The Academy does not believe that risk-adjusting for sociodemographic status holds providers to different standards but ensures that facilities are not unfairly penalized for serving vulnerable populations and, by doing so, having payments reduced, thus, reducing the available resources and worsening disparities in care.

**AAPM&R suggests that CMS consider the use of patient-reported data. Although we recognize that self-report has a possible risk related to sociodemographic differences in recall and reporting, we believe that it can be a valuable source of information. Furthermore, we believe that self-report offers a reasonably valid estimate of differences in utilization of health care between socioeconomic groups. In addition, the Academy recommends including functional status (activities of daily living, instrumental activities of daily living, and mobility) as a risk adjustment variable in order to accurately assess patients across post-acute care settings. The scientific literature contains many examples of the impact of functional limitations on mortality. For instance, use of a frailty adjustment factor or other metric would help adjust for variations in functional status of patients.**

*b. Proposal To Address the IMPACT Act Domain of Resource Use and Other Measures: Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program*

For FY 2018, CMS is proposing to adopt the measure, Discharge to Community—PAC SNF QRP, for the SNF QRP as a Medicare FFS claims-based measure. Measuring the rate that the various PAC settings discharge patients to the community, without an admission (or readmission) to an acute care hospital within 30 days, is one of the most relevant patient-centered measures that exists in the post-acute care area. During the measure development process, the Academy stressed to CMS the need for this measure to include function, be given greater consideration of available home and community supports, and address risk adjustment and exclusions more appropriately before adoption in any PAC setting. The Academy reiterates its comments on this measure during this rulemaking process.

Ideally, a post-acute care stay following an illness or injury will enable a person to recover and be rehabilitated so they may regain their health, lost skills and functions, and avoid readmission to the acute care hospital. Thus, permitting a person to regain enough function to return to independent living and resume their daily routine, their preferred community and social activities, employment if appropriate, as well as exercise and leisure activities. However, discharge to the community cannot occur unless an individual achieves sufficient functional improvement following illness or injury. Returning to one's previous home is only half the goal. The person should also be able to function to the greatest possible extent in the home and community setting and achieve the highest quality of life possible.

As proposed, the Discharge to Community—PAC SNF QRP, for the SNF QRP measure does not include metrics that assess, to a sufficient extent, the functional status/gains achieved by patients' subject to this measure. Existing functional measures in various PAC settings are well developed and are important indicators of recovery

and achievement of rehabilitation goals. These factors must be more intimately embedded in the proposed discharge to community measure. If this were to occur, this measure would be invaluable to patients and their families in assessing and comparing outcomes of various PAC providers.

**AAPM&R strongly urges CMS to delay its proposal to adopt this measure and work with the measure developers and interested stakeholders to more fully incorporate metrics that assess whether patients achieve functional and independence goals based on their plan of care and their specific condition.**

*c. Proposal To Address the IMPACT Act Domain of Resource Use and Other Measures: Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program*

The Academy generally supports CMS’s proposal to adopt the Potentially Preventable 30- Day Post-Discharge Readmission Measure and separate measures in each post-acute care setting for 30-Day Potentially Preventable Readmission. However, at some point in the future, as the silos of PAC settings begin to break down, by design from CMS, a uniform measure that assesses potentially preventable readmission post-discharge from the acute care hospital (regardless of which PAC setting the patient is referred to) will become more relevant. There is nonalignment with the equivalent IRF measure, making the SNF measure out of sync with IRF measure collection, creating the potential for confusion and lack of clarity in terms of potentially preventable readmissions.

*7. Skilled Nursing Facility Quality Measure Proposed for the FY 2020 Payment Determination and Subsequent Years*

*a. Quality Measure Addressing the IMPACT Act Domain of Medication Reconciliation: Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program*

In this Proposed Rule, CMS proposes the adoption of the quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues–PAC IRF QRP, for the IRF QRP as a patient assessment based, cross-setting quality measure. The Academy supports the general concept behind the medication reconciliation quality measure. However, we have reservations about CMS continuing to adopt measures that are not NQF endorsed. NQF is the national “gold” standard for verifying quality measures. Although most developers put their measures through a rigorous process long before NQF considers them for endorsement. NQF assess a measure to determine if the measure will have a positive impact on healthcare quality, is scientifically acceptable, is useable and relevant for quality improvement and decision making, and feasible to collect without undue burden. **Thus, the Academy urges CMS to allow the NQF to complete its vetting process for this measure before adoption.**

### *8. SNF QRP Quality Measures and Measure Concepts Under Consideration for Future Years*

AAPM&R supports the development and adoption of relevant, appropriate, and applicable quality measures for future years in the SNF QRP. However, the Academy has concerns with the current Request for Information process utilized by CMS to aid in the design and development of PAC measures. The current process is hurried and creates undue burden on most stakeholders who put their measures through a rigorous development process. Furthermore, the seven-and-fourteen-day comment periods with several last minute extensions are disruptive and unreasonable for stakeholders to adhere to.

### **C. SNF Payment Models Research**

In the FY 2015 Proposed Rule, CMS discusses why the Agency contracted with Acumen, LLC. The goal being to identify potential alternatives to the existing methodology used to pay for therapy services received under the SNF PPS. Since that time, CMS has implemented a comprehensive approach to Medicare Part A SNF payment reform, consequently expanding the scope of the SNF Therapy Payment Research project to examine potential improvements and refinements to the overall SNF PPS payment system. **AAPM&R seeks clarification from CMS on how future proposed changes to the SNF PPS system will impact, or be impacted by, additional CMS plans to revise how post-acute care is covered and paid. Additionally, the Academy urges CMS to ensure that all final system changes align, as not to create payment systems that place undue burden on facilities, providers, or patients.**

In this Proposed Rule, CMS also discusses the process for which expertise of the stakeholder community was sought to identify the most viable alternative to the current SNF payment model. Acumen developed technical expert panels (TEPs) made up of experts from across the SNF and post-acute care continuums to examine Acumen's research and provide their comments and direction on where Acumen's research should continue. The focus of one of the TEPs was the nursing component of the SNF PPS. This TEP included a discussion on the adequacy of nursing payments as well as discussion of non-therapy ancillaries (NTAs), such as drugs.

The TEP panel suggested many different factors that could influence what is currently encompassed by the nursing index. They include characteristics of the beneficiary/patient such as co-morbid conditions, medical complexity, functional status, cognitive needs, mood, mental health, dementia, malnutrition, and skin integrity. They also include factors concerning what treatments a patient needs – IV procedures, parenteral feeding, type of drugs needed, respiratory care, and others. Given the diversity of factors currently grouped into the nursing index, **AAPM&R supports the TEP's suggestion that NTA services be separately considered in conjunction with the nursing index and the quantity of therapy. Also included in**

**the NTA services should be care of a respiratory therapist, social worker, discharge planner, and etc. In addition, AAPM&R supports the inclusion of beneficiary characteristics such as the aforementioned mentioned characteristics, in computing the nursing index, rather than just nursing time.** This would comport well with the TEP recommendation that characteristics be used rather than time in determining appropriate resource use. As the TEP pointed out, the characteristics of SNF patients has changed noticeably over the past decade, with acute care hospitals discharging sicker patients in need of expanded resources to the SNF setting

The Acumen report “Skilled Nursing Facility Therapy Payment Models Technical Expert Panel Summary,” describes in more detail, suggests from the TEP on how to assign costs to therapy if a characteristics type approach is utilized. The TEP suggests that this approach would create cohesion between the different aspects of payment for SNF care – therapy, nursing, and NTAs. Additionally, the TEP points out that additional clarity is needed on the identification of the pertinent variables in assessing the need for therapy. The TEP also points out that while functional ability is mentioned as one of the characteristics to be looked at in assessing the need for therapy services, it is perhaps not afforded the importance it deserves. AAPM&R agrees that functional ability is vital in assessing the need for therapy services.

In fact, AAPM&R believes that functional goals and abilities are the best overall justification for receiving therapy services. While patient characteristics such as comorbidities, medical complexity, etc. are important to consider, they are more relevant in determining the amount of nursing and physician care the patient will need than in determining therapy participation, unless it is something that interferes with their ability to participate in and benefit from therapy. For example, a patient who has an inpatient diagnosis of acute ischemic stroke. That patient may have no functional deficits, or they may be obtunded, or they may fall somewhere in the middle. Although the patients have the same diagnosis, only the person who falls between the two extremes will benefit from extensive therapy at the time of admission. This is consistent with the data provided in the research, which concluded that therapy costs were lower for residents with very high or very low ADL scores on admission. Additionally, with the proper care in the home, the patient with no residual impairment may have the ability to be discharged to home. The patient who is obtunded may require a significant amount of skilled nursing care, and perhaps some therapy to evaluate seating and positioning systems. The obtunded patient may progress to the point where he or she can benefit from more extensive therapy, but at the time of admission, that is unknown. The patient with definite functional impairments who is at a level of consciousness where they can interact with their environment, will need the most comprehensive therapy program.

Another concern voiced by the TEP on Acumen’s research is the use of a summary scale to measure ADL function. The TEP discussed several alternatives, including a “late-loss ADL score” based on a scale from 1-24, which was created by Acumen, the



contractor overseeing the research; the CARE tool; the National Outcomes Measurement System; or a combination of tools. However, the TEP did cite problem in utilizing such scales, specifically, “A beneficiary could be highly functional on the total late-loss ADL score but be unable to go home because she cannot function alone in the kitchen.” The AAPM&R believes that the Acumen report does not account for other measurement tools that can be used in the SNF setting, for example, Functional Improvement Measure™ (FIM™). FIM™ is utilized by therapists working in rehabilitation and has been found highly accurate and reliable –It has two different scales – one for basic ADLs such as dressing and mobility, and one for higher level ADLs such as cooking and shopping or paying bills. However, even with this instrument, there must be a way to compare different types of data. For example, a patient scores a 7 (independence) in walking mobility. That does not tell you how far the patient can walk, whether the patient can balance on uneven or slippery surfaces, or whether the patient can go up and down curbs or stairs. Such information can be found in therapy notes but does not necessarily lend itself to scoring on a numerical basis.

The summary of the TEP also points out the pros and cons of using sociodemographic characteristics. As aforementioned, AAPM&R supports the utilization of sociodemographic characteristics for risk-adjustment and agrees with the TEP that the characteristics important in payment may not be the same as the characteristics important to care planning. The development of a care plan must also take into account the patient home environment in order to plan for a successful discharge. Whether knowing a patient is from a lower sociodemographic status will cause the SNF to consciously or unconsciously shorten the patients stay is something the panelists were wary of. However, AAPM&R reiterates its comment that risk-adjusting for sociodemographic status does not hold providers to different standards but ensures that facilities are not unfairly penalized for serving vulnerable populations and, by doing so, having payments reduced, thus, reducing the available resources and worsening disparities in care.

Although this Proposed Rule, along with the additional research documents, do not mention the possibility of another venue being more appropriate for a patient, it is indeed something important to consider. A SNF is set-up to function very differently than an IRF. In an IRF, patients are cared for by a team of professionals, who interact with the patient and with each other, and meet formally at least once per week to go over the patient’s progress, goals, and anticipated discharge date. There is generally a social worker or case manager on the team with extensive knowledge about the burdens and obstacles the patient may face on discharge and how to offset them. There is also a rehabilitation nurse on the team, who works with the patient on carryover of things learned in therapy, creating a bowel or bladder program to reduce the chances of incontinence, or education for the patient and family members on medications, emergencies, and other things they will need to be successful upon discharge. In many institutions the team is led by a physiatrist – a physician who specializes in physical medicine and rehabilitation. The physiatrist understands what each of the team members can do and orchestrates a planned series of interventions to

allow the patient to progress toward their goals. He or she is also alert to any medical changes that may occur in what may be essentially a new and different body for the patient. A physiatrist is attuned to not only the physical needs of his or her patients, but also their psychological needs. This is of utmost importance, since a patient admitted for rehabilitation has likely come through a traumatic event, whether it be a planned surgery or an accidental injury, and is facing the possibility of having to learn to accommodate changes in their bodily structures and functions. For this reason, the milieu of the rehabilitation hospital can also have a profound effect on a patient.

We appreciate the opportunity to comment on this proposed rule. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jenny Jackson, Manager of Finance and Reimbursement in the AAPM&R Division of Health Policy and Practice Services. She may be reached at [jjackson@aapmr.org](mailto:jjackson@aapmr.org) or at (847)737-6024.

Sincerely,



Phillip Bryant, DO  
Chair  
Reimbursement and Policy Review Committee  
American Academy of Physical Medicine and Rehabilitation