American Academy of Physical Medicine and Rehabilitation

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June 19, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1632–P
P.O. Box 8013, Baltimore, MD 21244–1850

**Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection; Proposed Rule**

Dear Mr. Slavitt:

On behalf of the more than 8,000 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 (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection; Proposed Rule*, that was published in the Federal Register on April 20, 2015. Physiatrists are specialists in the field of physical medicine and rehabilitation (physiatry) and treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and persons with neurologic disorders or any other disease process that results in impairment and/or disability.

**Additional Aspects of the SNF PPS**

*Consolidated Billing*

Sections 1842(b)(6)(E) and 1862(a)(18) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) requires that SNFs submit consolidated Medicare bills to Medicare Administrative Contractors for almost all of the services that a resident receives during the course of a covered Part A stay. However, a number of individual high-cost, low probability services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) are excluded.

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Customized prosthetic devices are among the categories of services excluded from SNF PPS under the provision of the Act and are identified in a list of excluded Healthcare Common Procedure Coding System (HCPCS) codes that is updated and published annually by CMS. AAPM&R continues to support the continued exclusion of customized prosthetic devices from the SNF PPS system as their inclusion among the services covered under a SNF PPS payment would make SNFs unlikely to admit and provide care to patients with limb loss.

**The Academy recommends the inclusion of two high-cost, low probability HCPCS codes, used to describe a component of an artificial limb, to the list of codes excluded from the SNF PPS Consolidated Billing program:**

- **L5969- Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s); and**
- **L5987- All lower extremity prosthesis, shank foot system with vertical loading pylon.**

**Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)**

AAPM&R strongly supports the promotion of high quality and efficiency in the delivery of health care to Medicare beneficiaries. Additionally, we believe that performance improvement leading to the highest quality health care requires continuous evaluation to identify and address performance gaps and reduce the unintended consequences that may arise in treating a large, vulnerable, and aging population. Therefore, AAPM&R recognizes that CMS faces unique challenges in the Prospective Payment System Proposed Rule for Skilled Nursing Facilities for FY 2016. For the coming fiscal year, CMS must weave together new components for skilled nursing facilities including payment approaches, value-based purchasing, health information exchange and quality reporting. Although not new for other Medicare providers, this is the first time these components have been included for SNFs in one regulation.

AAPM&R believes that valid, reliable, and relevant quality measures and instrument(s) are fundamental to the effectiveness of any quality reporting program. Additionally, quality measures that can transcend and ultimately break down the silos that currently exist in the PAC sector are pertinent to quality patient care. In order for such measures and instruments to be used effectively and to enable further reforms to post-acute care (PAC) service delivery and to associated payment models (such as a free flow of patients to appropriate settings during the rehabilitation process, site-neutral payments, payment bundling, or the transition away from individual setting regulations), the instrument(s) must be used in conjunction with other data to demonstrate the aspects of medical rehabilitation programs and services that promote best-care practices, in the appropriate setting, based on the needs of the individual patient and family/care-giver.

*General Considerations Used for Selection of Quality Measures for the SNF QRP*

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In this CY 2016 Proposed Rule, CMS is proposing to adopt for the SNF QRP three measures that the agency believes meets the following three domains: Functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; and incidence of major falls. The AAPM&R has concerns with the new measures.

The new quality measure, Functional status, cognitive function, and changes in function and cognitive function proposed in this rule is an application of the Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function. This is similar to what CMS proposed in the CY 2016 Inpatient Rehabilitation Facility (IRF) PPS Proposed Rule, however, it is important to note the differences in this measure versus the functional status measures that already exist in the IRF setting. This new measure has a different scale (6 versus 7 points), different measurement periods (look back periods differ) and different definitions (average score versus lowest score) than the current IRF Patient Assessment Instrument (IRF-PAI) utilized for payment. It is important that new measures are applied at a full scale and tested before enabling further payment reforms across PAC settings. **The Academy urges CMS to analyze data received from the new functional assessment measure over a period in conjunction with other data collected, such as through the IRF-PAI, and ensure they are receiving meaningful data that can inform best-care practices in order to support future payment reforms across PAC settings.**

AAPM&R continues to believe that new proposed measures should undergo validity and reliability testing, with reference to individual patient subpopulations. Additionally, research studies should be conducted to:

- Compare the CARE items against other valid and reliable instruments that are designed to measure function in diverse PAC populations, and the data then should be used to improve the CARE items or to replace it with other measures for the measurement of functional status across the continuum of care
- Study the tool's effectiveness in tracking functional improvements and decline longitudinally across the entire care trajectory, in particular to address the potential for ceiling and floor effects of the measure
- Compare models of care for subpopulations in order to find best practices for patients with moderate to severe disabling conditions; outcome measures should include reduction of disability and mortality, disease and symptom management, prevention of primary and secondary complications, patient and family/care-giver training, and patient satisfaction with the care experience.

AAPM&R is also concerned that the new proposed quality measures, while addressing functional improvement, do not address the practical value of the measurable improvement or the ability of a patient to return to the community. The Academy believes that measurement of patient and family engagement with the process of care and with education and training must be considered in the evaluation of PAC models. In

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addition, without factors related to psychosocial and family financial support in prediction models, changes in function from admission to discharge do not tell the entire story. **The Academy urges CMS to support the development of quality measures that relate to patient and family engagement as PAC reform implementation evolves. As such, the AAMPR is interested in collaboratively working with CMS and other interested stakeholders to develop more relevant quality measures.**

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 or at (847)737-6024.

Sincerely,

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