



June 26, 2018

Seema Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1696-P  
P.O. Box 8016  
Baltimore, MD 21244-1850

Re: CMS-1696-P Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for Fiscal Year 2019

Dear Administrator Verma:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments in response to the Fiscal Year (FY) 2019 Skilled Nursing Facilities Prospective Payment System proposed rule. AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). 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. Several of the provisions in the proposed rule will impact physiatrists nationwide. We therefore appreciate your consideration of the following comments.

**V. Proposed Revisions to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Case-Mix Classification Methodology**

AAPM&R supports updates to the SNF PPS which modernize SNF reimbursement. We appreciate that under the Patient-Driven Payment Model (PDPM), SNF payment will be based on beneficiary characteristics and care needs. The current time-based model of payment for SNFs does not appropriately reimburse for the wide range of patients receiving care in SNFs, many of whom have multiple comorbidities and/or complex conditions. If implemented correctly, payment under the proposed new methodology will be tied to each specific patient’s care needs.

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We caution that many aspects of the new methodology will create workflow and staffing challenges for SNFs. The changes are dramatic, and SNFs will be called upon to quickly change how they operate to accommodate the changes under the PDPM. Extensive staff education, adjustments to staff roles within facilities, and other changes may be necessary to meet the requirements of the new methodology. ***We therefore recommend that prior to the October 1, 2019 implementation date, CMS conduct significant educational efforts to ensure success of the new classification methodology.*** Below we have outlined our concerns with the PDPM and areas for increased education, as well as the aspects of the program we support.

#### *D. Proposed Design and Methodology for Case-Mix Adjustment of Federal Rates*

In the proposed rule, CMS describes its methodology for categorizing a resident into one of the ten proposed PDPM clinical categories. AAPM&R recognizes that, under the proposal, appropriate categorization would rely heavily on accurate ICD-10-CM coding and completion of line I8000 of the MDS on the part of the SNF staff. Furthermore, certain patients will need to be categorized using a secondary level of ICD-10-PCS coding. Based on input from our membership, SNF staff familiarity with accurate ICD-10-CM and PCS coding varies significantly from institution to institution. While much of this coding may be provided by the acute care hospital, under the PDPM the SNF staff will ultimately be responsible for accurate completion of the MDS. ***AAPM&R recommends that CMS develop explicit instructions for appropriate completion of item I8000 on the MDS as well as providing resources on diagnostic and procedural coding for SNF staff.*** The clinical examples provided within the text of the proposed rule were very helpful in understanding the implications of correctly coding the patient. We encourage CMS to consider developing additional case studies as a means of properly educating the SNF. AAPM&R also recognizes that this requirement will require workflow changes and potentially even require SNFs to hire workers with higher skill levels to complete the MDS. Failure to adjust to these changes may ultimately result in a SNF not being able to receive accurate payment under the PDPM.

AAPM&R applauds the efforts of CMS to account for all areas of therapy, as well as nursing and ancillary care in the case-mix classification proposal. We note that the proposal is a dramatic change and have some concerns as to whether patient acuity and complexity will be accurately measured. We recognize that as a part of its work, Acumen conducted analysis on admissions

in FY 2017 to develop the PDPM. We are concerned that a single year of data is insufficient to determine the accuracy of the model, and ***we strongly recommend that CMS assess the PDPM using additional data including FY 2016 data and FY 2018 data, once fully available, to ensure the robustness of the model over the FY 2016 through FY 2018 period. Further, AAPM&R recommends that CMS continue to monitor the accuracy of the PDPM following its implementation to ensure it continues to result in accurate payments over time.***

Additionally, AAPM&R recognizes that CMS has actively engaged stakeholders throughout the PDPM development process. We encourage CMS to continue this collaboration with discussion about transition plan development, implementation, and post-implementation problem solving. Specifically, ***AAPM&R recommends CMS form a standing stakeholder work group to address these issues. Further, we encourage CMS to include physiatrist representation on the work group and would welcome the opportunity to nominate one of our member experts.***

***E.1 Proposed Revisions to Minimum Data Set (MDS) Completion Schedule***

AAPM&R recognizes the need to set a specific mechanism for classifying the patient and establishing the per diem payment. We agree that the 5-day scheduled assessment will likely be the most appropriate tool for making this determination, and appreciate the reduction in burden associated with less frequent assessments. However, the addition of ICD coding as described above, as well as the complexity of determining when Interim Payment Assessments (IPAs) may be needed, suggest that significant training and education will be required to ensure SNFs are able to capture all necessary information in the assessments to allow for accurate payment. ***As such, AAPM&R recommends that CMS work to educate SNFs and their clinical staff prior to the October 2019 implementation of the PDPM so that they are prepared for this change.***

***F. Proposed Revisions to Therapy Provision Policies Under the SNF PPS***  
***AAPM&R supports CMS' proposal to set a combined limit on group and concurrent therapy to 25 percent of therapy received at the SNF.***

We recognize that this limitation is consistent with the limitations in IRFs currently, and we believe that consistency is appropriate. While we recognize that group and concurrent therapy may be appropriate in some instances, AAPM&R still encourages CMS to require facilities to deliver individualized care to patients as much as possible.

*G. Proposed Interrupted Stay Policy*

***AAPM&R supports the implementation of a SNF interrupted stay policy that is consistent with the policies in other post-acute care settings.*** We recognize that with the proposed changes under the PDP, which include variable per diem payment adjustments that provide higher payments at the beginning of the stay, implementing an interrupted stay policy will be appropriate for SNFs. As a further point of support, we note that under the current system, rates of discharge to institutions (such as acute hospital or emergency department) are monitored very closely. We expect that the proposed interrupted stay policy would allow for short term discharges where medically necessary while allowing for appropriate payment across a patient's stay.

**VI. Other Issues**

*B.3 Proposed new Measure Removal Factor for Previously Adopted SNF Quality Reporting Program (QRP) Measures*

CMS proposes to continue to rely on existing removal factors when considering whether to remove measures from the SNF QRP. CMS proposes a new removal factor: "Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program." In some instances when this factor is used as a justification for proposing to remove a measure, it may not necessarily be due to the "cost" imposed on the provider, but the cost imposed on CMS to administer. AAPM&R suggests this removal factor may be problematic if CMS proposes to remove a measure that clinicians or patients feel is important. ***AAPM&R requests that CMS adopt a more inclusive process, that accounts for the perspective of both patients and clinicians, when making measure removal determinations.***

**VII. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers**

AAPM&R supports CMS's interest in promoting interoperability and the exchange of electronic healthcare information for hospitals and other Medicare- and Medicaid-participating providers and suppliers. Additionally, AAPM&R appreciates CMS's recognition of the need to address health information technology adoption and interoperability among providers that were not eligible for the Medicaid and Medicare Electronic Health Record (EHR) Incentives programs, including post-acute care providers. Should CMS move forward with incorporating provisions into the Conditions of Participation (CoPs) and Conditions for Coverage (CfCs), AAPM&R opposes applying these

requirements to SNF providers that were not eligible for the EHR Incentive programs.

We appreciate the opportunity to comment on this proposed rule. If you have any questions about our comments, please contact Carolyn Winter-Rosenberg, Manager of Reimbursement and Regulatory Affairs in the AAPM&R Division of Health Policy and Practice Services. She may be reached at [cwinterrosenberg@aapmr.org](mailto:cwinterrosenberg@aapmr.org) or at (847)737-6024.

Sincerely,

A handwritten signature in black ink that reads "Annie D. Purcell, D.O." The signature is written in a cursive style with a large, stylized "D" at the end.

Annie Davidson Purcell, D.O.  
Chair  
Reimbursement and Policy Review Committee