June 20, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Acting Administrator Slavitt:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR), and other supporting organizations, appreciate the opportunity to comment on the proposed rule, *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research*. CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

Overview

The proposed rule updates the prospective payment rates for skilled nursing facilities (SNFs) for federal fiscal year (FY) 2017. It also proposes a SNF Value-Based Purchasing (VBP) Program including a SNF all-cause all-condition hospital readmission measure, as well as a SNF quality reporting program as required by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Due in part to the IMPACT Act, the rule focuses heavily on implementation of standardized data elements across post-acute care ("PAC") settings in order to facilitate quality measurement.

Notably, the rule does not include any pilots, demonstration projects, or more significant implementation of bundling of post-acute care, site-neutral payment between SNFs and other settings of care, or other post-acute care proposals contained in the President's most recent budget and recent MedPAC recommendations. CPR is grateful to CMS for choosing not to include these types of provisions in this rule, considering the serious reservations CPR members have with many of these proposals. We discuss this issue further in our comment letter below.

Meaningful Quality Measures Needed

To satisfy requirements of the IMPACT ACT, CMS proposes to add new measures to the SNF Quality Reporting Program ("QRP") to complement those measures already in place:

- Medicare Spending Per Beneficiary-post-acute care (MSPB-PAC);
- Discharge to Community (PAC SNF QRP);
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP; and,
- Drug Regimen Review Conducted with Follow-Up for Identified Issues.

We acknowledge the importance of these added measures to SNFs and other settings of post-acute care, especially the measure that assesses the percentage of patients discharged from PAC settings into the community. Many of the measures being implemented in the PAC setting are process measures, and those that are more akin to outcome measures are fairly rudimentary. CPR favors quality measures in PAC environments that accurately assess beneficiaries' functional status, addresses the real-life needs of beneficiaries, beneficiary experience, engagement, and shared decision-making measures.

For instance, as PAC quality measurement matures, we urge CMS to ensure that community-based functional measures are implemented so that beneficiaries with disabilities and chronic conditions will be better informed of their key concerns following illness or injury. These concerns certainly include the ability to achieve sufficient functional status to be discharged from a SNF and return to the home and community-based setting. They also include the ability to live as independently as possible; to function at the maximum extent possible; to return to employment if desired and appropriate; to engage in recreational and leisure activities; to exercise with or without assistive aids; to engage in community, civic and social activities; and to maintain the highest quality of life possible.

We discuss two of the proposed new measures for SNFs below. Additionally, CPR recommends that CMS further research and refine the development of risk adjusters for each of these measures that are more sensitive to the complexities of PAC beneficiaries, and to their levels of resource use. This would factor into the quality measures the real-life circumstances of beneficiaries and make the quality measures more sensitive to these important considerations.

Medicare Spending Per Beneficiary is Not a Quality Measure

CPR believes that the Medicare Spending Per Beneficiary post-acute care (MSPB-PAC) measure has very little to do with quality. Therefore, defining MSPB as a quality measure is not accurate. MSPB-PAC is nothing more than a measure of resource use across an episode of post-acute care. While relevant to assess how much the Medicare program invests in various levels of PAC services per patient, it does not inform the Medicare program, providers, or stakeholders of the value received for the Medicare program's investment or the functional gains achieved for level of care provided.

CPR supports the fact that CMS proposes a separate MSPB measure for each PAC setting. Establishing separate MSPB measures for each setting of post-acute care will enable CMS and providers to draw comparisons between providers of the same type, as opposed to comparisons across different types of providers.

CPR believes that using MSPB as a "quality" measure to compare care delivered in different PAC settings will create a major disincentive for referring acute care hospitals to send patients to more intensive PAC settings that are often more expensive in the short term. Using MSPB as a benchmark

in this manner is likely to lead to a systematic bias against referrals to more intensive PAC settings, even if the patient requires and can benefit from a more intensive and coordinated rehabilitation program. Further, MSPB scores do not reflect the longer-term savings that come from early functional gains by beneficiaries that may lead to independent living and less burden on health and social services and supports.

Therefore, in order to protect against diversion of beneficiaries to less intensive, inappropriate PAC settings as a result of widespread use of the MSPB measure, we recommend that the final rule include payment penalties that can be used by CMS to dissuade providers from using the MSPB measure to make referral decisions that inappropriately underserve beneficiaries with disabilities and chronic conditions.

Discharge to Community is a Critical Quality Measure that Must be Improved

The proposed discharge to community measure assesses successful discharge to the community from a SNF or other post-acute care setting. Discharge to community is a critical measure to assess the ability of a PAC provider to rehabilitate patients to enable them to return to the home and community-based setting, rather than remaining in an institution. This measure will be determined based on the code used for the "Patient Discharge Status Code" on the Medicare claim form.

A beneficiary will be considered discharged to community if their Patient Discharge Status Code on Medicare claims is one of the following:

- 01 - Discharged to home/self-care
- 06 - Discharged/transferred to home under care of organized home health service organization
- 81 - Discharged to home or self-care with a planned acute care hospital readmission
- 86 - Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.

Overall, CPR believes many of the elements of the measure specifications for the Discharge to Community (DTC) measure are appropriate. However, there is a major problem with this measure as it is applied in the SNF setting and this problem strikes right at the heart of the independent living movement.

Discharge to Community Definition Must be Modified

CPR would like to ensure that all PAC providers abide by the same standards in recording discharges to the community. We believe that discharging a beneficiary to a "residential" nursing home (*i.e.,* long-term care setting), especially if the patient is admitted from a Medicare-certified part of the same facility, should not be counted as a discharge to community. Unfortunately, the measure specifications as proposed would permit such a discharge to count as a community discharge. For instance, if a beneficiary in a skilled nursing facility (SNF) is discharged to a non-Medicare certified area within that same facility, the discharge may be interpreted as a discharge to a "group home," "foster care," or "other residential care arrangement."

Such discharges are nevertheless included under guidance for Patient Status Discharge Code 01, one of the codes that counts as a community discharge.[1] If such a discharge from a Medicare skilled nursing

[1] CMS Medicare Learning Network, *Clarification of Patient Discharge Status Codes and Hospital Transfer Policies*, MLN MATTERS NO. SE0801, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf (updated Mar. 6, 2014).

facility to another part of the same facility would indeed count as a community discharge, this would likely artificially improve the community discharge rates for SNFs with accompanying residential nursing home beds while holding other PAC providers to a different and potentially more stringent standard. As such, counting a discharge from a SNF to the residential/long-term care portion within the same facility as a discharge to community would not only negate the value of the measure itself, but would miscommunicate the actual discharge to community performance to the average Medicare beneficiary on any public reporting mechanism.

CMS has stated in the proposed rule that it will not adjust the quality measures, including the discharge to community measure, to account for the functional status of beneficiaries until such data is collected under the IMPACT Act. Adjusting for beneficiaries' functional status is critical and would enhance the accuracy of the discharge to community measure. Functional status has a direct and proven correlation with the setting to which a beneficiary is discharged, meaning that PAC providers who treat more functionally impaired beneficiaries will likely score lower on the discharge to community measure. With the present focus on care transitions and discharge planning, functional data will soon become a necessary component of quality measurement in both acute and PAC settings.

The presence of family or community supports is also a key indicator of a beneficiary's ability to be discharged to the community as well as their ability to remain in their home or community setting. Many PAC beneficiaries that live alone without the oversight or assistance of a family member or other community caregiver have a higher risk of readmission. Therefore, CPR recommends that CMS update the risk-adjustment factors for the discharge to community measure to include the functional status of beneficiaries and the presence of community supports available to beneficiaries.

CPR Supports Continued Exclusion of Customized Prosthetic Devices from the SNF PPS and the Exclusion of Additional HCPCS Codes

In the proposed rule, CMS invited comment identifying Healthcare Common Procedure Coding System ("HCPCS") codes under the prosthetic limb benefit that represent recent medical advances and might meet its criteria for exclusion from SNF consolidated billing. CMS stated that it may consider further exclusions of prosthetic devices/services if they meet its criteria for exclusion. CMS further stated that commenters should identify in their comments the specific HCPCS code that is associated with the device/service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

As discussed in the proposed rule, §1888(e)(2)(A) of the Social Security Act (SSA) excludes certain high cost, low probability services from the SNF PPS payment system. The reason for this exclusion is historical. The Balanced Budget Act of 1997 transitioned SNFs to consolidated billing and a per diem payment system, and prosthetic and orthotic care was originally included in this system. Shortly thereafter, Medicare data revealed that patients were no longer gaining sufficient access to prosthetic devices/services during the SNF stay, presumably because prosthetic care is individualized and relatively expensive in relation to SNF per diem payment rates. The theory behind exempting prosthetic codes from the SNF payment system was that SNFs could arrange for the provision of required prosthetic care for their patients during the SNF stay and the prosthetic provider or supplier could bill this care separately under Medicare Part B.

This has been permitted since passage of the Balanced Budget Refinement Act of 1999, which listed a significant number of exempted prosthetic HCPCS codes from the SNF payment system and gave

CMS authority to update this list in the future. CPR strongly supports the continued exclusion of customized prosthetic devices and related services from the SNF PPS system as their exclusion helps ensure timely and appropriate care to patients with limb loss in the SNF setting. Unfortunately, the 1999 law did not include a similar set of exempted HCPCS codes for custom orthotics.

Additional Prosthetic HCPCS Codes. The proposed rule seeks comment on any additional HCPCS codes that are not currently on the exclusion list but meet the requirements for exclusion under the provisions of the Act. In response to the CMS request in the proposed rule, CPR suggests the inclusion of two additional HCPCS codes to the list of codes excluded from the SNF PPS Consolidated Billing program. CPR believes the following HCPCS codes meet the statutory requirements for exclusion from SNF PPS and, therefore, should be added to the list of excluded codes.

- L-5969 - Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s); and
- L-5987- All lower extremity prosthesis, shank foot system with vertical loading pylon.

According to the proposed rule, for a code/service to be considered for exclusion from the SNF PPS, it must meet the criteria set forth in Section 103(a) of the Balanced Budget Refinement Act (BBRA). These criteria include:

1) The service/code must fall within one of the four established exempt categories under the BBRA (chemotherapy administration services, radioisotope services and customized prosthetic devices);

2) The code must be a high cost item/service, which would put an undue burden on the SNF because the cost of the item/service would exceed the SNF's payment under the PPS; and

3) The code must have a low frequency, or be provided to patients infrequently in a SNF.

CPR believes the two HCPCS codes listed above meet the established criteria. The above codes, which are used to describe components of an artificial limb, fall into the customized prosthetic device category as described in §1888(V) of the SSA. In addition, the above codes are high cost items/services and are provided to patients infrequently in a SNF. In addition to meeting the SNF PPS exclusion criteria, these prosthetic components are considered the standard of care and, if prescribed as medically necessary by a physician as part of a plan of care, should be exempt from the SNF PPS along with the vast majority of the prosthetic HCPCS codes that current enjoy this exclusion.

Importance of Excluding Custom Orthotic Codes. While the BBRA of 1999 did not make explicit reference to "custom orthotics," the custom orthotic and prosthetic professions are closely aligned and a sizable percentage of patients who require prosthetic care also require custom orthotics to address orthopedic impairments of the arms, legs, spine and neck. Custom orthotic treatment provided to appropriate inpatients of skilled nursing facilities can be invaluable in the recovery and rehabilitation from illness or injury, and can lead to significant improvements in functional outcomes when provided as part of a rehabilitation plan of care. The same factors that justify exempting prosthetic devices and related services from the SNF PPS similarly apply to custom orthotics (although this is not necessarily the case with off-the-shelf orthotics). Custom orthotics are typically a high cost device/service and are of low frequency for patients in SNFs.

The proposed rule states that CMS has the "statutory authority to identify additional service codes for exclusion" in order to afford sufficient flexibility to CMS to revise the list of excluded codes in response to changes of major significance that may occur over time. Based on this authority, CPR asks CMS to consider exempting from the SNF PPS certain customized orthoses that meet the same criteria for exclusion as prosthetics. Further, we suggest that in determining the list of custom orthotic HCPCS codes to exempt from the SNF PPS, CMS start by examining CMS Transmittal 656, CMS Manual System, Pub. 100-04 Medicare Claims Processing (August 19, 2005), which includes a list of HCPCS codes and descriptors of custom-fabricated orthoses, and updating that list to reflect changes to the HCPCS code set that have occurred in the past eleven years.

Medicare PAC Reform Requires Serious Deliberation and Reliable Data

All Medicare post-acute care (PAC) reforms that CMS considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation and should be based on reliable data that is comparable from one post-acute care (PAC) setting to another. Standardized data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect beneficiaries against underservice. Implementation of the IMPACT Act is beginning to serve this data collection purpose.

CPR favors payment and delivery models that are based on sound evidence with fully developed quality measures and risk-adjusters so that any savings are achieved through genuine efficiencies, not achieved by stinting on care. Implementing the same set of quality measures across PAC settings, as the IMPACT Act requires and the rule proposes, helps facilitate meaningful comparisons between settings of post-acute care.

Standardized data and quality measures across PAC settings can be used to develop a uniform quality assessment instrument to measure outcomes across PAC settings and design appropriate risk adjustment methodologies that protect against underserving beneficiaries with the most significant medical and functional needs. Such tools would be invaluable to developing and enacting PAC reforms that do not compromise care for people with disabilities and chronic conditions. This is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC beneficiaries under a bundled Medicare payment system achieve good outcomes and to ensure that risk adjusters accurately capture the unique needs of individual beneficiaries.

Until these and other beneficiary protections are in place, we do not support regulating or legislating PAC reforms that bundle episodes of care, impose financial incentives to treat beneficiaries in the least intensive setting, or otherwise limit rehabilitation benefits under the Medicare program. Therefore, we thank CMS for refraining from proposing PAC policies through regulation that are simply not well developed at this stage.

****

We greatly appreciate your attention to our concerns and your interest in our participation in this process. Should you have further questions regarding this information, please contact Peter Thomas or

Steven Postal, CPR staff, at (202) 466-6550 or by emailing Peter.Thomas@ppsv.com or Steven.Postal@ppsv.com.

Sincerely,

CPR Steering Committee

Judith Stein	Center for Medicare Advocacy	JStein@medicareadvocacy.org
Alexandra Bennewith	United Spinal Association	ABennewith@unitedspinal.org
Kim Calder	National Multiple Sclerosis Society	Kim.Calder@nmss.org
Amy Colberg	Brain Injury Association of America	AColberg@biausa.org
Rachel Patterson	Christopher and Dana Reeve Foundation	rpatterson@ChristopherReeve.org
Sam Porritt	Falling Forward Foundation	fallingforwardfoundation@gmail.com

Supporting Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Blue Ridge Independent Living Center
Brain Injury Association of America
California Foundation for Independent Living Center
Center for Independence of the Disabled, NY
Center for Medicare Advocacy
Child Neurology Foundation
Christopher and Dana Reeve Foundation
Coalition for Barrier Free Living
Disability Rights Education and Defense Fund
Disabled Resource Services
Easter Seals
Falling Forward Foundation
The Freedom Center, Inc.
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Council on Independent Living
National Multiple Sclerosis Society
National Stroke Association
New Yorkers for Accessible Health Coverage
Paralyzed Veterans of America
United Cerebral Palsy
United Spinal Association
Westchester Disabled On the Move, Inc.