October 14, 2015

DELIVERED VIA REGULATIONS.GOV

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2390-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: CMS-3260-P Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

Dear Acting Administrator Slavitt:

The Coalition to Preserve Rehabilitation (CPR) appreciates the opportunity to comment on the above-referenced proposed rule.[1] 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.

Resident Assessment (§ 483.20)

We urge CMS to include a minimum standard of service needs that must be shown if an individual is determined, as part of the preadmission screening for individuals with mental illness and individuals with intellectual disability under 483.20(k)(1), to require the level of services provided by a nursing facility. We believe CMS has the authority to define what it means to require the level of services provided by a nursing facility, and the lack of any federal definition has resulted in the preadmission screening requirements being largely ineffective in achieving the goals envisioned by Congress when it enacted those requirements.

Comprehensive Person-Centered Planning (§ 483.21)

The proposed rule states that the comprehensive care plan must describe the resident's preference and potential for future discharge. It further states that if discharge to the community is determined not to be feasible, the facility must document who made the determination and why. We urge CMS to add that if discharge is determined not to be feasible, the plan must document (1) the specific reasons for

[1] *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*; Proposed Rule, 80 Fed. Reg. 42168 (July 16, 2015). Available at: http://www.gpo.gov/fdsys/pkg/FR-2015-07-16/pdf/2015-17207.pdf.

that conclusion, (2) the services that the resident receives at the facility that could not be effectively provided in a community setting, and (3) the reasons why these services could not be provided in a community setting. We also urge CMS to add that, in determining a resident's preference for discharge, the facility must ensure that the resident has received full and accurate information about community options, including the services and financial benefits available to individuals in those settings. Lastly, we urge CMS to stipulate the timing and circumstances under which family members and/or guardians will be involved in planning and decision-making. In the event a person has specified his/her choice for discharge is to the home, the family member and/or caregiver must be notified adequately to arrange home modifications or other necessary arrangements to accommodate the individual's request.

Specialized Rehabilitative Services (§ 483.65)

According to the proposed rule, if the long-term care facility resident's comprehensive plan of care (discussed below) requires "specialized rehabilitative services" including but not limited to: physical therapy, speech language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity, the facility must obtain the required services from an outside resource from a Medicare and/or Medicaid provider of specialized rehabilitative services.[2]

This section adds respiratory therapy to the definition of specialized rehabilitative services. CPR supports the addition of respiratory therapy, and also encourages the addition of recreational therapy, to the definition as well, as recreational therapy is recorded in the MDS 3.0 for nursing homes under Section O.

CPR also requests that CMS change the term "specialized rehabilitative services" to "rehabilitative services *and devices*," to be consistent with CMS' final rule *Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2016*.[3] CPR recommends that the final rule adopt a federal regulatory definition of "rehabilitative services" that includes explicit recognition of coverage of *devices*. The final rule should use the National Association of Insurance Commissioners' (NAIC) definition of rehabilitative services, codified in the February 2015 final rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*[4] and the SBC Uniform Glossary.[5] We recognize that the February 2015 rule applies to private insurance under the Affordable Care Act, but we believe that the rehabilitation benefit should be consistent across healthcare to the maximum extent possible.

Rehabilitative devices should also be covered whether or not they are considered part of the skilled nursing facility (SNF) per diem rate or separately billable to the Medicare program. We also recommend that CMS add more robust definitions for rehabilitative devices into § 483.65, such that this term includes durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

---

[2] *Id.*, at 42263.

[3] *Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2016*, Federal Register, Vol. 79, No. 228 (November 26, 2014), at 70717.

[4] *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, Federal Register, Vol. 80, No. 39 (February 27, 2015), at 10811. Available at: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

[5] "Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings." See http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

Outpatient Rehabilitation Services (§ 483.67)

CPR recommends that CMS modify § 483.67 to be consistent with the suggested changes in the above section (Specialized Rehabilitative Services (§ 483.65)):

> § 483.67 Outpatient rehabilitati***ve*** services ***and devices***.
> If the facility provides outpatient rehabilitati***ve services and devices***, physical therapy, occupational therapy, audiology, or speech pathology services, the services must meet the needs of the patients in accordance with acceptable standards of practice and the facility must meet the following requirements: …
>
> (b) Personnel. (1) The facility must assign one or more individuals to be responsible for outpatient rehabilitative services ***and devices***. The individual responsible for the outpatient rehabilitative services ***and devices*** must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services ***and devices***.
>
> (2) The facility must have appropriate professional and nonprofessional personnel available at each location where outpatient services ***and devices*** are offered, based on the scope and complexity of outpatient services ***and devices***.
>
> (c) *Delivery of services.* (1) Services ***and devices*** must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under state law.
>
> (2) All rehabilitati***ve*** services ***and devices*** orders and progress notes must be documented in the patient's clinical record…

Behavioral Health Services (§ 483.40)

In the proposed rule, § 483.40 enumerates staffing and other facility requirements for the provision of behavioral health services. The provision also highlights facility requirements in the event that rehabilitative services, including therapy, are provided.[6] CPR recommends adding a new section § 483.40(e) which reads as follows:

> (e) The facility must provide recreational therapy services to attain or maintain the highest practical mental and psychosocial wellbeing of each resident.
> (f) The facility must provide crisis intervention services
> (g) The facility must offer employment services to any resident requesting such assistance and support.

The Coalition to Preserve Rehabilitation (CPR) strongly encourages CMS to recommit to assertive implementation of PASARR (Pre-Admission Screening and Annual Resident Review). PASARR is intended to deflect from admission persons more appropriately supported by other placements. It is intended to put in place the most appropriate and helpful person-centered plans prior to admission, and to continually revise and adapt person-centered plans to provide supportive services and assistance that residents need, including to facilitate their timely discharge.

[6] *Reform of Requirements for Long-Term Care Facilities,* at 42261.

Compliance with *Jimmo v. Sebelius*

For all rehabilitative services and devices relevant to this proposed rule, CPR recommends that the proposed rule be in compliance with the recent *Jimmo v. Sebelius* decision, i.e., that Medicare coverage is available for skilled services to maintain an individual's condition. Pursuant to *Jimmo*, medically necessary nursing and therapy services, provided by or under the supervision of skilled personnel, are covered services by Medicare if the services are needed to maintain the individual's condition, or prevent or slow their decline. The rule should make explicitly clear that a resident need not demonstrate improvement in order for skilled services to be covered as reasonable and necessary services.

Care Planning (§ 483.21)

In this proposed rule, CMS requires each facility to complete a baseline care plan for each resident within 48 hours of their admission to the facility.[7] This would eliminate the possibility that residents could reside in a facility for 21 days without any care planning.[8] CPR supports this timely identification of resident needs and initiation of care.

Discharge Planning Process (§ 483.21(c))

According to the proposed rule, the facility must develop and implement an effective discharge planning process from transitioning each patient from SNF to post-SNF care. This includes providing assistance in selecting post-acute care providers for residents entering a post-acute care setting such as a home health agency (HHA), inpatient rehabilitation hospital, long-term care hospital (LTCH), or another SNF. To facilitate this, the discharging facility must use data that includes, but is not limited to SNF, HHA, inpatient rehabilitation hospital, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. Additionally, the facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.[9]

CPR further suggests that these provisions contain more explicit language stating that the long-term care facilities should proactively monitor their residents for clinically appropriate opportunities to discharge them to other post-acute care facilities, including inpatient rehabilitation hospitals, to maximize the chances that residents will eventually be able to return home and live independently.

Resident Rights (§ 483.10)

The proposed rule grants residents the right to be informed of "treatment and treatment alternatives or treatment options and to choose the alternative[s] or option[s] [they prefer]."[10] CPR recommends that CMS clarify that these treatment alternatives or treatment options include the option to be treated in other more intensive rehabilitation settings such as inpatient rehabilitation hospitals.

Binding Arbitration Agreements (§ 483.70(n))

CPR has serious concerns with the imposition of binding arbitration agreements between SNFs and SNF residents since the language as written could severely undercut residents' rights and make the current pre-dispute arbitration system *significantly worse* for nursing facility residents.

---

[7] *Id.*, at 42256-7.
[8] *Id.*, at 42193.
[9] *Id.*, at 42257.
[10] *Id.*, at 42247.

Definitions (§ 483.5)

CPR supports adding "licensed or certified respiratory therapist" and "licensed or certified recreational therapist" to the definition of licensed health professional:

> *Licensed health professional*. A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; licensed or certified social worker; ***licensed or certified respiratory therapist; and licensed or certified recreational therapist.***

This revision would make the definition consistent with our proposed revisions of the definition of Specialized Rehabilitative Services at § 483.65.

Quality of Care and Life (§ 483.25)

Activities. CPR supports a change in this section in order to make it more precise. CPR supports modifying § 483.25(c)(2)[11] in the following manner:

> The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-
>
> (i) Is licensed or registered, if applicable, by the State in which practicing; and
>
> (ii) Is:
>
> (A) Eligible for certification as a therapeutic recreation specialist ~~or as an activities professional by a recognized accredited body on or after October 1, 1990;~~ or
>
> ~~(B) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a therapeutic activities program; or~~
>
> (C) Is a qualified occupational therapist or occupational therapy assistant.~~; or~~
>
> (D) ~~Has completed a training course by the state~~.

These regulations are dated as written, and our requested revisions reflect contemporary practice.

Special requirements for CAH providers of Long-Term Care Services (''Swing-Beds'') (§ 485.645)

In parallel with the change to § 483.25(c)(2) above, CPR recommends that CMS change § 485.645 in the following manner in order to avoid confusion in this regulation:

> (5) Patient activities (§ 483.25(c)), except that the services may be directed ~~either~~ by a qualified professional meeting the requirements of § 485.25(c)(2)~~, or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy~~.

****

[11] *Id.*, at 42258.

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 Steven Postal, CPR staff, by emailing Steven.Postal@ppsv.com, or by calling 202-466-6550.

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)	samporritt@aol.com

Endorsing Organizations

ACCSES
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Therapeutic Recreation Association
The Arc of the United States
Association of Rehabilitation Nurses
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Falling Forward Foundation
Lakeshore Foundation
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
Paralyzed Veterans of America
Parkinson's Action Network
United Spinal Association