



June 19, 2015

SUBMITTED VIA REGULATIONS.GOV

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-1622-P) 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

Dear Acting Administrator Slavitt:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on 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](#). 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) 2016. It also proposes a SNF all-cause all-condition hospital readmission measure, and for CMS to adopt a SNF Value-Based Purchasing (VBP) Program and a SNF quality reporting program as stipulated in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), signed by the President into law last October. The proposed rule also amends requirements for a long-term care facility to qualify as a SNF in the Medicare program and for nursing facilities (NFs) to participate in the Medicaid program. CPR supports that the proposed rule does not include many problematic provisions that the Centers for Medicare and Medicaid Services (CMS) could have pursued in this rule. Due in part to the IMPACT Act, the rule focuses heavily on implementation of quality reporting and payment.

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, recent

MedPAC recommendations, or Congressional bills and hearings. 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.

Quality Reporting Program

CPR appreciates the opportunity to comment on the SNF Quality Reporting Program as mentioned in this proposed rule, namely the data collection for the following two quality measures: Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) and Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay (NQF #0678).

The proposed rule states that there is no discharge assessment required when a beneficiary is discharged from a Medicare Part A stay but remains in the facility, which affects approximately 30 percent of SNF residents.¹ To address this, CMS proposes to add a new item set in addition to the 5-Day PPS Assessment. The CPR Coalition supports CMS' draft of the new MDS 3.0 PPS Part A Discharge (End of Stay) assessment.

The CPR Coalition strongly supports CMS' intent to require a discharge assessment. A lack of discharge data on Medicare beneficiaries who may no longer have their services covered as skilled services under Medicare Part A in the SNF but remain in the nursing home remains a significant challenge to compare data across post-acute care (PAC) settings. Standardizing and comparing such data is one of the key objectives of the Improving Post-Acute Care Transformation (IMPACT) Act of 2014. Requiring a discharge assessment for the 30 percent of SNF patients who become nursing home residents and do not currently receive such an assessment is therefore critical. Discharge assessment data for all PAC settings enable better understanding, for providers and CMS, of the needs and outcomes of PAC beneficiaries. The Medicare Payment Advisory Commission (MedPAC) likewise supports collection of uniform data across PAC settings. In its March 2015 Report to Congress, MedPAC "recommended that CMS collect uniform patient assessment data from the PAC settings to enable more complete comparisons of providers' costs and outcomes."²

Meaningful Quality Measures Needed

CPR favors quality measures in PAC environments that accurately assess patients' improvement and function. As PAC reform proceeds, CPR requests that CMS ensures that new PAC delivery models do not save Medicare dollars by stinting on patient care. Aside from what is mentioned in the above section, the quality measures as discussed in this proposed rule are fairly rudimentary and do not address key concerns of beneficiaries with disabilities and chronic conditions, including, where appropriate: the ability to live as independently as possible; to function at the maximum extent possible; to return to employment where appropriate; to engage in recreational and athletic pursuits; to engage in community activities; and to maintain the highest quality of life possible.

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

CPR would also like to comment on the provisions relevant to Section IV (B): Consolidated Billing. 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.

¹ Page 22026.

² *Report to Congress: Medicare Payment Policy*. The Medicare Payment Advisory Commission (MedPAC). March 2015.

Customized prosthetic devices. Certain customized prosthetic devices are among the categories of services excluded from the SNF PPS under the provisions 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. CPR supports 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/or provide timely care to patients with limb loss.

Additional HCPCS codes. The proposed rule encourages suggestions for 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 that other HCPCS codes be added 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.

- 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.

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 § 103(a) of the Balanced Budget Refinement Act (BBRA). These 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 provided to patients infrequently in a SNF.

CPR believes the HCPCS codes listed above meet the established criteria. The above codes, which are used to describe a component 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.

Lastly, the proposed rule states that CMS has the “statutory authority to identify additional service codes for exclusion as essentially affording the flexibility 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 orthotic devices that meet the same criteria for exclusion of prosthetic devices.

Medicare PAC Payment Reform Requires Serious Deliberation and Reliable Data

All Medicare post-acute care 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. Uniform and current data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. Implementation of the IMPACT Act now serves 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 patient care. Unfortunately, a “bundled” PAC payment system that includes these critical beneficiary protections does not currently exist and, we expect, will take several years to develop, adequately test, and validate. This is why we support refraining from either regulating or legislating “site-neutral” PAC payments or taking other PAC reform actions until data is collected and analyzed under the authorities enacted in the IMPACT Act.

This data can be used to develop a uniform quality assessment instrument to measure outcomes across PAC settings. Such a tool would be invaluable to developing and enacting PAC reforms that do not compromise patient care. This is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC patients under a bundled Medicare payment system achieve good patient outcomes and risk adjusters accurately capture the unique needs of individual patients.

Until these and other patient protections are in place, we do not support regulating or legislating PAC reforms that bundle episodes of care, impose financial incentives to treat patients in the least intensive setting, or otherwise limit rehabilitation benefits under the Medicare program. It is simply too risky to Medicare beneficiaries to implement PAC bundling or related reforms prematurely.

Therefore, we thank CMS for refraining from proposing PAC policies in this proposed rule that are simply not well developed at this stage. We request that CMS take sufficient time to collect data under the IMPACT Act’s provisions, and this proposed rule and future rules, before adopting a short-term, underdeveloped, approach to PAC reform that may negatively impact the recovery and rehabilitation of some of Medicare’s most vulnerable beneficiaries.

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,

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Endorsing Organizations

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American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Therapeutic Recreation Association
Amputee Coalition
Association of Academic Physiatrists
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
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National Association for the Advancement of Orthotics & Prosthetics
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
United Spinal Association