American Academy of Physical Medicine and Rehabilitation

aaPM&R

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
www.aapmr.org

phone 847/737.6000
fax 847/754.4368
info@aapmr.org

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June 22, 2017

Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1679-P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: CMS 1679-P Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition and Proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020

Dear Administrator Verma:

On behalf of the more than 10,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the proposed rule: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition and Proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020 that was published in the Federal Register on May 4, 2017. Physical medicine and rehabilitation (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. Many provisions in the proposed rule will impact physiatrists nationwide. We therefore appreciate your consideration of the following comments.

Comments on Consistency in SNF Coverage Across MACs

A concern regarding SNF coverage has been voiced by many of our member physiatrists, particularly those located in Michigan and Indiana. Our members have received denials from Wisconsin Physician Services (WPS) for visits to their patients in skilled nursing facilities or sub-acute rehab facilities. It is not

clear on what Medicare rule the denials are based. WPS has no Local Coverage Determination (LCD) for either Evaluation and Management codes or SNF coverage. AAPM&R is extremely concerned about the variability in coverage of SNF services across MACs. We urge CMS to take efforts to educate MACs in the different requirements for quality rehabilitation as it appears that certain MACs are unclear on what a physiatrist does and the importance the role of a physiatrist plays in successful rehabilitation outcome.

V. Other Issues

B.2.a. Measuring and Accounting for Social Risk Factors in the SNF QRP

AAPM&R believes that the scientific literature has provided many examples of sociodemographic factors that directly contribute to the development of disease and the
importance to risk-adjust for them, including the ASPE report. The AAPM&R strongly believes that measures should include sociodemographic factors such as socioeconomic status of the individual/family the resources available in the community in which the patient resides, and work status. The Academy does not believe that risk-adjusting for sociodemographic status holds providers to different standards. Risk-adjustment helps ensure that facilities are not financially penalized for serving vulnerable populations which can further reduce resource availability and worsen care disparities.

AAPM&R suggests that CMS consider the use of confidential patient-reported data. Although we recognize that self-report poses possible risks related to sociodemographic differences in recall and reporting, we believe that it can be a valuable source of information, if kept confidential. Furthermore, we believe that self-report offers a reasonably valid estimate of differences in utilization of health care between socioeconomic groups. In addition, the Academy recommends including functional status (activities of daily living, instrumental activities of daily living, and mobility) as a risk-adjustment variable to accurately assess patients across settings. The scientific literature contains many examples of the impact of functional limitations on mortality. For instance, use of a frailty adjustment factor would help adjust for variations in functional status of patients.

7.b. b. Proposed Functional Outcome Measures

AAPM&R supports outcome measures in post-acute care environments that accurately assess patients' functional status, whether the treatment is improving, maintaining, or slowing deterioration of function. AAPM&R cautions, however, that the data collected may be affected by educational level

and the professional expertise of the evaluator that will need to be factored into conclusions based on the data.

9. SNF QRP Quality Measures Under Consideration for Future Years
While AAPM&R appreciates the opportunity to comment on measures being proposed in FY 2020, it can be difficult when not all measure specifications are complete. We hope that CMS will provide more opportunity to comment on these again in the future. AAPM&R would also like to suggest that CMS continues to align new measures in every Post-Acute Care setting. During our review of the quality measures being proposed, we noticed that not all proposed measures cover every setting. We believe the measures make sense and could be implemented in every PAC setting.

- Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)
    - AAPM&R does not believe that pain experience alone should be a quality measure. As we stated above, solely asking about the presence of pain does not provide enough information to help an individual's overall quality of life improve. Pain levels may never change, even when the function/ability of the patient does. "Pain as the firth vital sign" caused opioid prescribing to soar and rephrasing these measures could be a huge opportunity for change. AAPM&R suggests modifying this measure to reflect the proportion of patients for which moderate to severe pain interferes with or prevents important daily functional tasks.
- Percent of SNF Residents Who Newly Received an Antipsychotic Medication
    - AAPM&R does not believe this is an actual "quality" measure since there is no baseline and we urge CMS to either reconsider this measure or continue the development of it.

10.a. Proposed Standardized Resident Assessment Data Reporting for the FY 2019 SNF QRP
Standardizing patient assessment data amongst Post-Acute Care (PAC) settings is important work that greatly impacts AAPM&R's members. To comprehensively state AAPM&R's support for data standardization, we developed Recommendations on Post-Acute Care Data Standardization and Quality Measurement that was approved by AAPM&R's Board of Directors in June 2016. This document is intended to show our support for moving towards standardizing data elements across PAC settings if reliable, feasible and risk adjusted methods are at the forefront of doing so. Attached at the end of this

comment letter is AAPM&R's official stance on data standardization across PAC settings.

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 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 or at (847)737-6024.

Sincerely,

Annie Purcell, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation

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APM&R Recommendations on Post-Acute Care Data Standardization and Quality Measurement

Background

Medicare spending on post-acute care provided by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals accounted for approximately 10 percent of total Medicare spending in 2013, totaling $59 billion. The Medicare Payment Advisory Commission (MedPAC) has noted several long-standing problems with the payment systems for post-acute care (PAC) and has suggested refinements that are intended to encourage the delivery of appropriate care in the right setting for a particular patient's condition. Several recent federal laws have affected, or will affect, payments to one or more post-acute care providers, including physicians who provide services in these settings. These federal laws include the Patient Protection and Affordable Care Act of 2010 (ACA), the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). However, new legislation is also being considered by lawmakers that may accelerate payment reform of post-acute care, possibly including value-based purchasing.

AAPM&R Position on Post-Acute Care Data Standardization and Quality Measurement

Data standardization across PAC settings is critical to compare and contrast care episodes in the various PAC settings. Not only will data standardization help facilitate appropriate payment reforms, it is also important to the development of appropriate quality measures that reflect the setting in which rehabilitation care is being provided. AAPM&R supports outcome measures in post-acute care environments that accurately assess patients' functional status, whether the treatment is improving, maintaining, or slowing deterioration of function. AAPM&R cautions, however, that the data collected may be affected by educational level and the professional expertise of the evaluator that will need to be factored into conclusions based on the data.

AAPM&R continues to advocate for post-acute care quality measures that are based on sound evidence with fully developed risk-adjusters. The following are requirements extracted directly from the IMPACT Act on data standardization and quality measurement across post-acute care settings in three areas, from high level domains to standardized assessment categories with specific data elements within each. AAPM&R supports these requirements. ***However, AAPM&R continues to stress to lawmakers and interested stakeholders that risk adjustment is necessary for comparison purposes and needs to be further studied for reliability.***

IMPACT Act Requirements Supported by AAPM&R

The IMPACT Act of 2014 requires The Secretary to implement specified clinical assessment categories using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers. The Act further requires that CMS develop and implement quality measures from five quality measure domains using standardized assessment data. In addition, the Act requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community. These domains and categories are listed below.

Through the use of standardized quality measures and standardized data, the intent of the Act, among other obligations, is to enable interoperability and access to longitudinal information for such providers to facilitate coordinated care, improved outcomes, and overall quality comparisons. AAPM&R supports the following measure domains, assessment categories and data elements as specified in the IMPACT Act.

I. ***Quality Measure Domains:***

- *Skin integrity and changes in skin integrity;*
- *Functional status, cognitive function, and changes in function and cognitive function;*
- *Medication reconciliation;*
- *Incidence of major falls;*
- *Transfer of health information and care preferences when an individual transitions*

II. ***Resource Use and Other Measure Domains:***

- *Resource use measures, including total estimated Medicare spending per beneficiary;*
- *Discharge to community; and*
- *All-condition risk-adjusted potentially preventable hospital readmissions rates.*

III. ***Assessment Categories:***

- *Functional status*
- *Cognitive function and mental status*
- *Special services, treatments, and interventions*
- *Medical conditions and co-morbidities*
- *Impairments*
- *Other categories required by the Secretary*

IV. Data Elements for Each Standardized Assessment Category

In order to compare outcomes across post-acute care settings, specific data elements must be identified and collected for each of the standardized assessment categories. AAPM&R recommends collection of the following data elements in each assessment category.

- Functional Status
  - Self-Care
    - Data elements of self-care should include eating; showering/bathing; upper body dressing; lower body dressing; toileting and medication management. Depending on the patient's goals, there may be a need to evaluate more complex abilities (Instrumental Activities of Daily Living) such as cooking, laundry, shopping, driving, money management, and using a telephone and computer.
  - Mobility
    - Data elements of mobility should include measurement of a patient's unique capacity for mobility, whatever form it takes. Data collected should include bed mobility, the ability to transfer from bed to chair, come from sitting to standing and to complete a car transfer. If a patient is expected to be able to ambulate, data collected should include: distance able to ambulate on level surfaces indoors; go up and down 1 step (curb); 4 steps; 12 steps; and ambulate on uneven surfaces and the use of an assistive device. If a patient is expected to primarily use a wheelchair, data should include safe wheelchair use (e.g. locking the wheelchair before transfer), the distance rolled, the ability to navigate more complex environments (such as turns or uneven surfaces) and the ability to go up and down a ramp.
- Cognitive and behavioral function
  - General Mental status including alertness and orientation
  - Evaluation of memory, attention, concentration
  - Evaluation of mood, agitation and pain
- Communication function
  - Ability to understand and express verbal and written information
- Special services, treatments and interventions provided such as
  - Pulmonary treatment/ventilator
  - Dialysis
  - Chemotherapy and other intravenous medications
  - Enteral nutrition
  - Use of assistive devices (DME, orthotics/prosthetics, communication devices)
- Medical conditions and co-morbidities such as
  - Diabetes
  - Pressure Ulcers

- Post-surgical or complex wound care
- Respiratory failure, tracheostomy
- Heart failure, cardiac monitoring

- Impairments
  - Bowel and Bladder function and level of patient independence
  - Swallowing function
  - Visual impairment
  - Hearing impairment
- Environmental factors
  - Community and family support
  - Access to community for basic needs
  - Access to transportation
  - Independent living status, with or without long term services and supports
  - Ability to return to work

Future Quality Measurement of PAC Services

It is important for PAC settings to move from the current emphasis on process measures and toward a series of outcome-related measures to compare and contrast between PAC settings and to assess short-and long-term patient status post-injury or illness. This requires data standardization across PAC settings in a series of important domains, as detailed above. Once achieved, quality measurement in the PAC arena needs to expand toward assessment of quality of life and long-term functional outcomes, such as those community-oriented factors described in the International Classification of Function (ICF), including the ability to live independently, return to work (where appropriate), community participation, social interaction, and other factors that indicate the true value of rehabilitative care.