



June 26, 2017

VIA ELECTRONIC SUBMISSION

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the proposed rule entitled, *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* (the Proposed Rule). 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) 2018. In an effort to continue to shift Medicare payments from volume to value, CMS also proposes additional policies and measures for the implementation of the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP) and the Skilled Nursing Facility Quality Reporting Program (SNF QRP) as well as an update on the SNF Payment Models Research (PMR) project. The proposed rule also includes a proposal for the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP), and includes a request for information on CMS flexibilities and efficiencies, among other things.

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 structural post-acute care proposals. 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 in greater depth after our primary comments below.

Meaningful Quality Measures Needed

CMS proposes to adopt four new outcome-based functional measures that address functional status for FY 2020, and invites comments on these measures. These measures align with the IRF Quality Reporting Program for FY 2020:

- Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633);
- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634);
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and
- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).

These are important new measures that we support in the SNF setting and in other settings of post-acute care. 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 and address the real-life needs of beneficiaries, including beneficiary experience, engagement, and shared decision-making measures. The four measures proposed herein move SNF quality measurement in this direction. Measuring the change in a patient's self-care and mobility status between SNF admission and discharge is an important functional measure that can be readily compared across PAC settings.

As PAC quality measurement continues to mature with implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, 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 perform activities of daily living; 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.

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 the rationale for requesting that the identified HCPCS code(s) be excluded.

Exclusion of prosthetic limb codes from the SNF PPS/consolidated billing rules has been shown to dramatically improve access to reasonable and necessary prosthetic limb care during patient stays at skilled nursing facilities. 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 rest of the prosthetic HCPCS codes that currently enjoy this exclusion.

Importance of Excluding Custom Orthotic Codes. While the BBRA of 1999 did not make explicit reference to “custom orthotics,” 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 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.

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. We also do not support proposals that would 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 Steve Postal, CPR staff, at (202) 466-6550 or by emailing Peter.Thomas@powerslaw.com or Steve.Postal@powerslaw.com.

Sincerely,

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Academy of Spinal Cord Injury Professionals
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
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