PUBLIC COMMENT SUMMARY REPORT

Project Title:

Development of Functional Outcome Quality Measures for Skilled Nursing Facilities (SNFs)

Dates:

The Call for Public Comment was open from October 7, 2016 through November 4, 2016.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International to develop Functional Outcome Quality Measures for Skilled Nursing Facilities (SNFs). The contract name is Development and Maintenance of Symptom Management Measures. The contract number is HHSM-500-2013-13015I. As part of its measure development process, CMS requests interested parties to submit comments on the candidate or concept quality measures that may be suitable for this project.

Project Objectives:

- To obtain input on functional status quality measures that may be used in skilled nursing facilities (SNFs).
- To examine the following potential measures:
  - An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
  - An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
  - An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
  - An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
- To specify the target population(s), including the inclusion and exclusion criteria
- To identify the case-mix adjustment variables and the approach for case-mix adjustment

Information About the Comments Received:

We solicited public comments using the following methods:

- Posting Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities on the CMS Public Comment website https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html (Note: the original document can now be accessed on the following website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html)
- Email notification to relevant stakeholders and stakeholder organizations
- Email notification to the measure's Technical Expert Panel members

Volume of responses received: CMS received 14 comment letters in total with all letters containing more than one comment. Comment letters were submitted by a range of stakeholders, including industry associations, professional associations and providers.

Two comments of the 14 comment letters were outside of the scope of this public comment opportunity. Those comments were subsequently forwarded to the appropriate CMS measure teams.

Stakeholder Comments—General and Measure-Specific

This report provides a summary of public comments received and CMS's responses to the public comments. CMS would like to thank all commenters for sharing their comments, concerns, and suggestions.

In general, CMS received considerable support for the functional outcome measures. We appreciate concerns shared by commenters, and have provided responses and clarifications regarding these issues. Several commenters suggested modifications to the measure specifications, which we will carefully consider and update where appropriate and feasible. We would like to note that CMS continuously evaluates measures with the intent to improve quality measures, and considers modifications that optimize performance of quality measures. The last section of this report includes a table containing the verbatim text of all public comments received.

1.1 Overall Feedback on the SNF Quality Measures

Support for Functional Outcome Measures

Summary: CMS received several comments in support of the functional outcome quality measures. One commenter expressed general support for the goal of improving health care quality. Another supported the use of quality measures focused on the outcomes of care rather than quality measures focused on process of care. One commenter voiced support for function measures and items that are significant to residents and providers. One commenter supported measuring function to better understand improved or declining resident function and the relationship of these outcomes to SNF facility-characteristics. Several commenters supported functional status quality measures that report improvement and aim to promote maximum independence, and noted the importance of measures that examine maintenance of function or slowing of deterioration in function. Several commenters explicitly stated their support for measuring self-care and mobility in the SNF setting. One of these commenters voiced their appreciation for CMS's acknowledgement that these quality measures are not intended to be all-inclusive measures addressing all aspects of function. One commenter expressed support for both the change score and discharge score quality measures and indicated that the change score measures are more actionable for providers.

Response: CMS appreciates the support from the commenters who expressed support for the SNF functional outcome measures. CMS agrees that patient and resident functioning in the areas of self-care care and mobility are an important area of quality in post-acute care (PAC) settings, and account for specific aspects of patient and resident functioning.

Measure Importance, Value, and Validity

Summary: Several commenters expressed concerns or asked for clarification about the function measures. One commenter requested clarity on the value of the data collection and on the validity of the quality measures. Another commenter cautioned that function measures are not "one size fits all" and that measurement should consider the quality of life domain for all residents. One commenter noted that the quality measures should have the following characteristics: have a long history of being reliable and valid; be predictors of quality, cost and payment; and be endorsed, approved, or found "best in class" by stakeholders and the National Quality Forum (NQF). The commenter further noted that these quality measures are not endorsed for use in the SNF setting by the NQF, and that CMS should consider similar and competing measures. This commenter suggested that CMS seek NQF review of the measures for use in the SNF setting.

Response: CMS appreciates the commenters' input regarding the importance, value, and validity of the quality measures. We agree that a 'one size fits all' approach cannot be applied for the SNF functional status quality measures. For this reason, the specifications include several exclusion criteria for the SNF self-care and mobility outcome measures. For example, one set of exclusion criteria relate to medical conditions and another set of exclusion criteria relate to incomplete stays. CMS strongly agrees that item and quality measure validity and reliability are important, and that the self-care and mobility items would ideally be used for multiple purposes, such as risk factors for quality measures and information transferred when residents are transferred from one setting of care to another.

Because the standardized self-care and mobility items are intended for use across PAC provider settings, establishing feasibility and the scientific acceptability of the items across the PAC settings were and remain important goals for CMS. The standardized self-care and mobility Continuity Assessment Record and Evaluation (CARE) items underwent several types of testing across acute and post-acute care settings as part of the Post-Acute Care Payment Report Demonstration (PAC PRD). This testing, which included data from SNFs, assessed the items' feasibility, reliability, and validity. Details regarding the reliability and validity testing, can be found in reports entitled *The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set, Volumes 1 through 3*, *Continuity Assessment Record and Evaluation (CARE) Item Set: Video Reliability Testing,* and *Continuity Assessment Record and Evaluation (CARE) Item Set: Additional provider-Type Specific Interater Reliability Analyses.* These reports are available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html.

Sixty SNFs (contributing almost 4,000 CARE assessments) participated in the PAC PRD, which included the collection of standardized CARE assessment data from a total of 206 acute and PAC providers. The *PAC-PRD Final Report* can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

We appreciate the commenters' feedback with respect to NQF endorsement, and recognize the importance of consensus endorsement. Where possible, we seek to adopt measures for the SNF QRP that are endorsed by the NQF. To the extent that we adopt measures under our exception authority, we intend to seek NQF endorsement of those measures and will do so as soon as is feasible. Regardless of whether the measures are or are not NQF-endorsed at the time we adopt them, they have all been tested for reliability and validity, and we believe that the results of that

testing support our conclusion that they are sufficiently reliable and valid to list them as measures under consideration for the SNF QRP. It should be noted that these measures are currently NQF endorsed for the IRF setting.

Standardization

Summary: Several commenters expressed support for movement toward the development and implementation of a core set of functional status items that are standardized across PAC settings. Two commenters cited the importance of being able to make fair and meaningful comparisons of residents'/patients' functional status across PAC providers, and two other commenters specifically supported utilizing the four IRF functional outcome measures in the SNF setting. Another commenter offered their support for measures that have been used by providers in all PAC settings. While two commenters expressed concern that these measures are not standardized and cross-setting (IMPACT Act), two other commenters noted that preserving clinical accuracy while moving toward standardization of data elements and quality measures was important.

Response: CMS appreciates the support expressed by commenters for the development and implementation of a core set of functional items that are standardized across PAC settings. We recognize the importance of standardized items for specific outcomes, while also recognizing that there are some differences in patients' and residents' clinical characteristics, including medical acuity, across the LTCH, SNF and IRF settings, and that certain functional status items may be more relevant for certain patients/residents. We also refer commenters to Table 3 in the Technical Expert Panel Summary Report: Development of Functional Outcome Quality Measures for Skilled Nursing Facilities (SNFs) (available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/SNF-Function-Quality-Measures-TEP-Summary-Report-August-2016.pdf), which shows the item level standardization.

We would also like to point out that several of the self-care and mobility items are already in use in the SNF setting. The quality measure, an Application of the Percent of LTCH Patients with a Functional Assessment and a Care Plan that Addresses Function (NQF #2631), was finalized for use in the SNF Quality Reporting Program (QRP) in FY 2016 (Federal Register 80;46444 through 46453),and includes some of the self-care and mobility items included in the SNF functional outcome measures under consideration.

1.2 Measure Specifications and Function Items: Comments Related to All Four Measures

Item Alignment

Summary: CMS received several comments related to the functional assessment items. Three commenters recommended a review of current SNF measures and items so that the addition of any new items would align with existing data collection and any duplicative or overlapping items could be deleted. Another commenter further asked that CMS consider the ADL index and its use for payment if the existing Section G items are removed.

Response: CMS appreciates concerns raised with respect to duplication of items. We are sensitive to burden and have developed the measures with this in mind. As an example, in the existing section GG, we have included several gateway questions that allow the clinician to skip items in the assessment instrument that are not pertinent for an individual resident/patient, which reduces burden. Overall, while many of the G items and standardized functional assessment items in section GG appear to be similar, the specific language, coding, and measurement characteristics differ. The

items in section GG were developed with input from the clinical therapy communities to better measure the change in function, regardless of the severity of the individual's impairment. As we develop quality measures, we review existing items and consider the appropriateness of adding or deleting any items.

We acknowledge the comment regarding payment and Section G items, and will take this into consideration.

Rating Scale

Summary: Several commenters expressed concern regarding the measure scale in Section GG, which ranges from 01 - Dependent to 06 - Independent. Two commenters thought that including residents who do and do not require medical devices in the same category (i.e., 06 - Independent) is an oversimplification of function assessment, may result in the inability to distinguish resident progress, and relates to resident safety concerns. These commenters thought that the current scale overstates progress at the bottom (i.e., going from 01 - Dependent to 02 - Substantial/Moderate Assistance) while understating progress at the top (i.e., changing from 05 - Setup or Clean-Up Assistance to 06 - Independent). The commenters recommended more precise scaling to increase sensitivity and accurately represent improvements. One commenter voiced concerns regarding two of the coding options: 1) 04 - supervision and touching assistance and 2) 02 - substantial and maximal assistance. Regarding the former, this commenter believes that there is a meaningful functional difference between supervision assistance and touching assistance and that this combination may result in a misunderstanding of the level of assistance needed. Regarding the latter, the commenter expressed concern that this category is too broad, does not reflect the actual level of assistance needed, and will result in difficulties detecting functional improvement and deterioration. The commenter believes these categorizations may inadequately represent the care needed from family members or caregivers once discharged and may result in readmissions.

Response: CMS appreciates the commenter's comments pertaining to the sensitivity of the functional assessment rating scale. We would like to note that when considering sensitivity, the rating scale and the items should both be taken into consideration. The 6-level rating scale was developed with input from a technical expert panel, and was designed to reflect the type and amount of assistance required from a helper for a person to complete daily activities. In addition, the development of the self-care and mobility items involved a careful review of all the existing data sets, literature reviews, and discussions with clinicians and researchers about the strengths and limitations of the existing instruments.

The development team focused on better measurement of patients/residents who have significant functional limitations by specifying different codes for persons who are totally dependent and those who manage to complete a small amount of an activity. The code 04 - Supervision or touching assistance is defined as requiring assistance from a helper, but the helper does not need to provide lifting assistance. Supervision assistance may be provided during the entire time that a resident completes an activity, and in such situations, the amount of time providing supervision is important to recognize. Analysis of the rating scale and items was conducted during the development of the CARE Item Set. Details regarding testing can be found in *The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set, Volumes 1 through 3*, at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html.

As noted above, the sensitivity of an instrument is related to the items included in the instrument in addition to the rating scale. The self-care and mobility items include a range of difficulty, including eating, bed mobility and more challenging daily activities such as picking up an object from the floor. With regard to the commenters concerns about inability to detect resident progress, in the PAC PRD, the overall mean (± standard deviation) change in mobility Rasch measures across post-acute care settings was 14.6 ± 14.6 units with the mean change being 16.6 ± 15.2 units in the SNF sample. Overall, the mean change in self-care Rasch measures across settings was 12.4 ± 13.8 units, with the mean change being 12.4 ± 12.8 units in the SNF sample. Results for the analysis of functional outcomes from the PAC PRD can be found in Tables 8-8 and 8-9 in the following link: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/PAC-PRD_FinalRpt_Vol4of4.pdf.

We would also like to clarify that the purpose of the proposed functional status quality measures is not to justify need for assistive devices or family needs, but rather to measure functional status and change in functional status of residents with device use, if indicated.

Usual Performance Scoring

Summary: One commenter recommended care be defined as the resident's lowest or minimal performance instead of the proposed "usual performance."

Response: CMS acknowledges the commenters concern regarding coding a resident's "usual performance." When a resident's performance varies during an assessment period, we believe that the resident's usual status offers the best estimate of the residents' need for assistance.

Recoding "Activity Not Attempted" Codes

Summary: Two commenters requested clarity on how missing data are handled in the quality measure calculation, and specifically sought further explanation from CMS on the recoding of "activity not attempted" codes (i.e., 07, Patient/Resident Refused; 09, Not Attempted, and 88, Not Attempted Due to Medical Conditions or Safety Concerns). These commenters noted that the "activity not attempted" codes are recoded to 01, Dependent and voiced concern about this approach. The commenters provided several reasons for their concern. First, one commenter stated that recoding to 01 may create a statistically significant difference in the change score calculation. Second, this commenter believes the recoding instruction conflicts with guidance that "clinical inferences" should not be made and providers should code 88 if something cannot be assessed. Third, another commenter suggested that recoding would inaccurately reflect residents' functional status or changes between admission and discharge. This commenter further questioned the need for coding options 07, 09, and 88, if their meaning is not used or considered. The commenters recommended additional analyses on the impact of recoding.

Response: CMS appreciates the concerns presented by commenters about handling missing data and the 'activity not attempted' codes. As the commenters indicated, the 'activity did not occur' codes are recoded to 01, Dependent in order to calculate the quality measure. When a resident cannot attempt an activity due to a medical condition or safety concern, often the resident would have required significant assistance from one or more helpers to the complete the activity had the activity had been attempted. Thus, the resident would have been considered dependent with the activity. Likewise, the code 09 is used to indicate that the activity was not attempted, and that the resident did not perform the activity prior to the current illness, injury or exacerbation.

1.3 Measure Specifications and Function Items: Comments Related to the Self-Care Measures

Summary: CMS received several comments specific to the self-care items and measure specifications. Two commenters explicitly supported the self-care items for eating, showering/bathing, upper body dressing, lower body dressing, and toileting hygiene. One of these commenters noted concerns that "wash upper body" is not in the item set, as it is in the LTCH CARE Data Set. They recommended adding this as either a required item or part of a skip pattern. Two commenters suggested that medication management (e.g., the ability to self-medicate or the ability to understand a medication regimen) be included as an additional self-care metric in the quality measures.

One commenter sought clarification on the coding for the eating self-care item, specifically asking how providers should code a resident who relies on tube feedings, or a resident who cannot feed him/herself, but can manipulate, chew and swallow food.

Response: CMS thanks commenters for their support of the self-care items. With regard to the exclusion of the item Wash Upper Body, we would like to point out that the item Bathe/Shower Self, which focuses on washing the entire body, is included as a self-care activity. The activity Wash Upper Body overlaps with the activity Bathe/Shower Self, was discussed during a cross-setting functional status Technical Expert Panel meeting, and the experts indicated a preference for including the item that focused on bathing the entire body, Wash/Bathe Self, when it is feasible to assess that activity. In IRFs and SNFs, clinicians typically assess showering or bathing of the entire body. For the LTCH setting, patients are chronically critically ill and often have significant functional limitations, therefore bathing the upper body is included on the LTCH CARE Data Set.

We would like to clarify that the item Eating is only scored when a resident eats by mouth. If a resident does not eat by mouth, and relies on an alternative means of getting fluids and nutrition, the item Eating is coded as "activity does not occur." If a resident eats by mouth, the code reflects assistance needed due to hand/arm movement limitations, cognitive limitations or swallowing limitations.

We appreciate the suggestion to include medication management as an additional self-care metric, and we will keep this in mind for ongoing development of the SNF functional quality measures.

1.4 Measure Specifications and Function Items: Comments Related to the Mobility Measures

Mobility Item Support and Requests for Clarification

Summary: CMS received several comments specific to the mobility items and measure specifications. Two commenters explicitly supported the mobility items related to bed mobility, transfer from bed to chair, sit to stand, car transfer, ambulation on level surface, ambulation on uneven surface, and stairs. One commenter, in contrast, expressed concern regarding the number of ambulation and stair items, and suggested that these constructs may overly influence residents' performance scores. This commenter sought clarification on the necessity of multiple stair and ambulation items. They note that providers may inappropriately use their resources to target these 2 functional outcomes and not the other domains.

This commenter further indicated, based on their own analysis of IRF-PAI data, that in the IRF industry there are too many "activity not attempted" codes being utilized on some of the mobility

items (i.e., 07, Patient/Resident Refused, 09,- Not Applicable, and 88,- Not Attempted Due to Medical Conditions or Safety Concerns). The commenter expressed concern that the mobility items are difficult to assess at admission and particularly noted the items car transfer, walk 150 feet, walk 10 feet on uneven surface, pick up object, and the three stair items. The commenter requested evidence that supports the value and appropriateness of these items in measuring functional change from admission to discharge.

Response: CMS thanks commenters for their support and recommendations to improve upon the mobility measures. In response to commenter concerns regarding the number of items, we would like to note that we selected activities that would allow assessment of functional improvement from admission to discharge, which includes activities of varying difficulty, in order to capture a varying range of functional abilities.

The walking and stair items assess unique levels of functional ability under varying circumstances. For the walking items, the distances 10, 50 and 150 feet are distinct and the item regarding walking 50 feet includes two turns. For example, a resident may be able to walk 10 feet in a room or corridor without help, but may require supervision or touching assistance to walk 50 feet while making two turns and may not be able to walk 150 feet due to their medical condition. The item Walk 10 feet on uneven surfaces is defined as the ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.

The same concept applies to the stair items. The items 1 step (curb), 4 steps and 12 steps consider the need to walk up and down a single step or a curb in the community, 4 steps may be negotiated to enter a home, and 12 steps are often climbed to reach the second (or higher) level in a home. Negotiating 12 steps is a more challenging activity for residents than negotiating 4 steps. Picking up object is an important functional activity that is commonly assessed by physical and occupational therapists. This item assesses an activity that can place residents at risk for a fall if not performed safely.

CMS would also like to clarify that clinicians should code that an activity was not attempted if an activity cannot be assessed or is not relevant for a resident. We recognize that some activities, such as car transfers, 4 and 12 steps, picking up an object from the floor and walking on uneven surfaces, are not typically performed at admission, but are important activities to assess at discharge for residents who are returning home.

Wheelchair Mobility Items and Coding

Summary: CMS received three comments related to residents who use a wheelchair and coding of wheelchair mobility items. One commenter thought it was important to distinguish those residents who are expected to use a wheelchair after discharge and those who would not use a wheelchair after discharge. This commenter further noted that this subgroup of residents should be assessed on items such as locking the wheelchair before a transfer, navigating turns and uneven surfaces, rolling forward, and going up and down ramps.

Two commenters expressed concerns regarding the wheelchair mobility items. Both noted that these items are not included in the change in mobility quality measure (NQF #2634), for residents who are not walking on admission. They also stated that for both quality measures the walking items are skipped for residents unable to walk even if there is a goal for walking. These commenters suggested that the current design of the mobility quality measures does not account for residents

discharged using a wheelchair and may affect the measure values for these residents resulting in inconsistencies across residents with different functional abilities.

These two commenters made several recommendations to address their concerns regarding the wheelchair items. Both commenters recommended additional testing to determine if the existing risk-adjustment methodology provides consistency for scoring residents who walk and those who do not. One commenter recommended inclusion of these items in the change in mobility quality measure (NQF #2634), excluding the walking items for residents who do not walk and replacing them with the wheelchair items, so that progress in wheelchair mobility is included for these residents. One commenter asked CMS to consider a risk adjustment model specific to residents who do not walk. Additional recommendations included the removal of mobility items that cannot be assessed by all residents, removal of all walking items except those that have an equivalent wheelchair item, and for CMS to consider the Uniform Data System (UDS) change in mobility measure (NQF #2321).

Response: CMS would like to thank commenters for their input on the wheelchair items. We recognize the importance of wheelchair mobility for SNF residents who rely on a wheelchair or scooter for self-mobilization. We discussed the option of using the wheelchair mobility codes instead of walking item codes for residents who self-mobilize via a wheelchair or scooter with our Technical Expert Panel, and received positive feedback about this approach. We appreciate hearing the additional support for this approach through this public comment opportunity. With regard to the walking gateway question and associated skip pattern, we would like to clarify that when the walking items are skipped, these items are re-coded to 01, Dependent.

1.5 Inclusion/Exclusion Criteria

General Comments

Summary: CMS received two general comments regarding the inclusion and exclusion criteria for the function quality measures. One commenter explicitly supported the full list of measure exclusions provided in the draft specification document. Another commenter expressed concern that there are too many exclusions for these measures, and that consequences of this could be manipulation of the quality measures by providers or that some facilities may have resident populations that are too small to be statistically meaningful.

Response: We appreciate the feedback about the list of measure exclusions provided in the draft measure specifications document. The proposed exclusion criteria would exclude residents who would not be expected to show improvement or would have less predictable improvement using the selected self-care and mobility items. We identified the exclusion criteria based on the input from clinical experts. Because the types of residents treated in SNFs varies across SNFs, exclusion criteria and risk adjustment are critical features of outcome measures.

Expectation of Functional Improvement

Summary: Three commenters indicated they supported including only residents with an expectation of functional improvement in the functional change measures. Two commenters voiced concerns about the appropriateness of not including all residents. These commenters indicated that the exclusion of residents not expected to show functional improvement resulted in an inconsistency with the IRF measures, and that the criteria would result in small numbers of residents for SNFs. One

commenter's opinion was that risk adjustment should be sufficient to account for these circumstances, and felt that the exclusions were not needed and may affect access to care within other PAC settings. This commenter asked CMS to do additional testing on the exclusion criteria. The second commenter noted that this exclusion may result in "gaming" and noted that an expectation should not serve as the determinant in how a measure is crafted.

Several commenters questioned how residents with an expectation of functional improvement would be identified and requested CMS clarify this exclusion's methodology and intent. The concern stemmed largely around the potential subjectivity and inconsistency among providers in determining whether a resident has an expectation of functional improvement. One commenter requested CMS put safeguards in place to ensure valid reporting. Commenters offered several suggested approaches for identifying these residents. One commenter recommended using risk adjustment to account for level of impairment, functional status, comorbidities and onset of condition to exclude residents. This commenter also suggested only including residents who receive physical therapy, occupational therapy, and/or speech language therapy in the measures. Another commenter suggested CMS remove those with an expectation of functional improvement from the population retrospectively and identify variables used for exclusion. Two commenters expressed concern regarding changes to a resident's functional status and/or expectation for functional improvement after admission. One of these commenters further stated that goals can change during the stay, and noted that the measure has no way to capture this information since scores are only assessed at admission and discharge.

Response: CMS notes the commenters' concerns regarding identification of residents with an expectation of functional improvement in an objective and consistent manner. The change in self-care and mobility quality measures are intended to capture improvement in self-care and mobility function from admission to discharge for residents who are admitted with an expectation of functional improvement. We thank commenters for their suggestions, and we will take these suggestions into consideration.

Residents coded as 06, Independent on all self-care and mobility items at admission are excluded from the respective measures because no improvement can be measured with the same selected set of items by discharge. Including residents with limited expectation for improvement can introduce incentives for SNF providers to not admit these residents. The unintended impact may be that SNFs that do admit these residents may show smaller average functional improvement.

We would like to note that the discharge self-care and mobility score quality measures do *not* exclude residents who have maximum self-care and mobility scores, respectively, at admission.

Regarding the concern that the admission assessment will not capture changes to a resident's functional status and/or expectation for functional improvement after admission, CMS would like to clarify that residents with incomplete stay are excluded from the quality measures.

Discharge Location

Summary: Two commenters requested revisions to the exclusion of residents discharged to hospice. One commenter suggested that this exclusion include an appropriate timeframe after the SNF discharge (e.g., 7, 14, or 30 days) and noted that a hospice admission may not occur immediately upon SNF discharge. The second commenter requested that CMS include residents discharged to hospice in the measures and thought that excluding these residents may impact their care. Another commenter recommended that CMS consider clarifying the definition of "residents discharged directly to another SNF," which is part of the incomplete stay exclusion.

Response: CMS appreciates the concern regarding the exclusion of residents discharged to hospice, and the suggestion of examining post-SNF discharge hospice utilization. We will consider this recommendation in future measure development. We anticipate that residents discharged to hospice have less potential for functional improvement.

With regard to identifying residents who were discharged to another SNF, MDS item A0310F reports the resident's discharge destination.

Medicare Managed Care Residents

Summary: Several commenters questioned the inclusion of only Medicare Part A residents in the measure and suggested CMS expand the measure to include Medicare Managed Care residents in the future. One of the concerns regarding this exclusion was that that the measures are not comparable to the IRF setting. One commenter further recommended use of the functional outcome measures as an indicator of quality across all payers.

Response: We thank the commentators for this feedback. We appreciate the interest in implementing functional outcome measures across all payers. For the purposes of the function outcome measure for SNFs, we only include the Medicare Part A population. We appreciate the comment that it would be beneficial to include all residents, regardless of payer for these measures, and will consider this measure refinement in the future.

Swing-Bed Residents

Summary: Two stakeholders provided comment on the exclusion of residents in swing beds in critical access hospitals. One commenter recommended that CMS include swing-bed residents in the quality reporting program and subsequently include this population in the function measures. The other commenter requested further study of this population before inclusion.

Response: Thank you for submitting this comment. We exclude residents of swing beds in critical access hospitals, because there is not a requirement for these providers to submit MDS data for these residents. Data used to calculate these quality measures are collected via the MDS, and thus access to MDS data is necessary. We appreciate the comment that consideration and study should be completed regarding this issue within the SNF quality reporting program.

1.6 Risk Adjustment

General Comments

Summary: CMS received many comments regarding risk adjustment. Several commenters expressed their overall support for risk adjusting the four function outcome measures. One commenter expressed their appreciation for CMS's addition of risk adjusters recommended by the Technical Expert Panel (TEP), while another commenter recommended additional testing and validation of the TEP's suggestions. Several commenters requested CMS continue to evaluate and refine the reliability of the risk adjusters.

A few commenters recommended CMS use the same methodology across PAC settings to allow for valid comparisons. Several commenters requested additional clarification on the risk adjustment methodology and indicated it was difficult to provide comments on the specifications that were available. One commenter raised concern regarding the use of the PAC PRD data to develop risk adjusters, because this commenter indicated the number of SNF facilities in the demonstration was inadequate. One commenter requested CMS put a process in place for adjustment and rectification if providers are penalized and it is later determined risk adjustment was inaccurate.

Response: CMS appreciates the comments in support of and recommendations to improve upon risk adjustment for these measures. We agree with commenters regarding the importance of appropriate risk adjustment such that functional status quality measures reflect real differences in the effectiveness of treatments provided by SNFs. We selected the risk factors based on literature review, clinical relevance, Technical Expert Panel input, and empirical findings from the PAC-PRD analyses.

As previously stated, there are some differences in patients'/residents' clinical characteristics, including medical acuity, across the LTCH, SNF and IRF settings, and risk adjustment methodology was developed and will continue to be refined in a manner that addresses these differences. To compare functional outcomes across SNFs, we adjust for differences in the mix of residents within those SNFs. Similar to our risk adjustment in the IRF setting, we would adjust data by calculating risk adjustment scores to measure how facilities are performing relative to how they would be expected to perform given their case mix. The model controls for resident factors for function discharge scores and functional change such as demographic and clinical characteristics. We have examined various risk factors using an ordinary-least squares regression to evaluate the direction and magnitude of the coefficient, statistical significance, and expected clinical relationship with the self-care or mobility outcome. This process estimates the relationship between patient/resident factors and the outcome. Our final model will use a generalized estimating equation (GEE) to account for clustering at the SNF level.

Regarding sample size, we have used the data from the PAC PRD to develop the functional status quality measures. The PAC PRD included 60 SNFs, and data on almost 4,000 residents to calculate the SNF self-care and mobility functional status measures.

We understand expressed concerns around risk adjustment. CMS aims to develop accurate and fair measures and will continue to do so. As previously noted, CMS continuously examines the performance of quality measures and revises measures to optimize measurement of quality.

Primary Medical Condition

Summary: Several commenters raised concerns about the risk adjustment group "Primary Rehabilitation Diagnosis." There were questions about where on the Minimum Data Set (MDS) this information would be derived, how SNF residents would be categorized into these groups, what type of SNF clinician would make this assignment, and what the proposed look-back period would be for these diagnoses. One commenter was concerned about the applicability of the diagnosis groups for residents in SNFs noting that not all SNF residents are admitted for rehabilitation as they are in the IRF setting. Another commenter recommended continued assessment and updating of these diagnosis categories based on new information and data collected.

A few commenters requested a crosswalk between Impairment Group Codes on IRF and the SNF Primary Rehabilitation Diagnosis and any applicable ICD-10 codes to aid in the understanding of these risk adjusters. One commenter noted their concern with using ICD-10 coding, stating it requires multiple levels of consideration and clinical input, and that multiple diagnoses and therapy diagnoses can be coded for a single resident.

Two commenters recommended CMS make the distinction between emergent and elective in relation to the Primary Rehabilitation Diagnosis "hip and knee replacement." Commenters noted that this is stratified for payment. One of the commenters suggested further evaluation of the two categories to determine if the split is appropriate.

One commenter supported the inclusion of invasive mechanical ventilation and other pulmonary treatments in risk adjustment for the function measures. Several commenters noted that the "conditions requiring invasive mechanical ventilation" risk adjuster was not included in the IRF measures and urged CMS to be consistent across PACs whether that means including this item in the IRF measures or removing it from the SNF measures. One commenter requested clarification on where this information will be derived from in the MDS and expressed concern that the MDS currently does not differentiate between ventilation and respiration.

One commenter requested clarification on the definition of a medically complex condition.

Response: CMS would like to thank commenters for their input and recommendations. In the development of the quality measures, we have used diagnosis information from the acute care stay prior to the SNF stay as well as the diagnosis data reported for the SNF stay. We would like to clarify that the Hip and Knee Replacement group includes residents with primarily elective surgery on the hip or knee. Residents who experienced a femur facture are included in a separate group, Fractures and Other Multiple Trauma.

BIMS

Summary: One commenter requested that CMS clarify in the assessment and all materials that the BIMS is a measure of short-term memory and is not a comprehensive assessment of a resident's cognitive ability.

Response: Thank you for your comment. As outlined in the Resident Assessment Instrument (RAI) User's Manual, the BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all aspects of cognitive impairment, and the final determination of the level of impairment

should be made by the resident's physician or mental health care specialist. The BIMS score was significantly associated with functional outcomes and is used as a risk adjuster in the SNF Functional Outcome measures.

Prior Functioning: Functional Cognition
Summary: Two commenters asked for clarification on how the item pertaining to functional cognition would be collected.

Response: Thank you for your comment. The prior functioning variables we tested as part of the PAC PRD assess residents' functioning immediately prior to the current (most recent) illness, injury, or exacerbation. For example, if the resident who was living at home had cognitive impairments prior to admission to an acute care hospital, the prior functioning variable assesses cognitive functioning at home before the acute care admission. Prior cognitive functioning was found to be significantly associated with functional outcomes, and is a risk adjuster in the SNF Functional Outcome measures.

Communication
Summary: Two commenters recommended changes to the communication risk adjuster. They both suggested qualifiers or gateway questions be used to determine both the mode (i.e., verbal, written, gesture, or assistive device) and level (i.e., word, sentence, or conversational) of communication. One commenter indicated that there is an important distinction between mild impairment and no impairment, and that these two categories should not be combined as the reference group.

Response: CMS appreciates the commenters concerns. We will take these recommendations into consideration as we continue to develop the functional outcome measures.

Swallowing Ability
Summary: A few commenters provided feedback on the swallowing risk adjuster. One commenter suggested CMS label this risk adjustment category as "eating" instead of "swallowing ability" because the term eating is more inclusive and appropriate. Two commenters recommended qualifiers or gateway questions to align this item with the new PO (by mouth) status in the "Rules of Participation for Long-Term Care Facilities." One commenter suggested refining the assessment items for oral intake of patients/residents using enteral feeding for swallowing disorders. Another commenter indicated that the swallowing group "modified food consistency/supervision" combined two unrelated levels of assistance and was concerned that improvements to eating unsupervised would go unrecognized. This commenter further noted that CMS should provide clear instructions to providers that the maximum level of assistance is to be reported, for example, that a resident can be on regular food but still needs supervision.

Response: We would like to clarify that the focus of this risk adjustor is for a swallowing problem (an impairment) and not adjustment for the activity of eating. The activity of eating is already a risk factor with the self-care items. The item Eating is scored only when residents eat by mouth. If a resident does not eat by mouth and relies on an alternative means of getting nutrition, the item Eating is coded as "activity does not occur." If a resident eats by mouth, the score may reflect assistance needed due to hand/arm movement limitations, cognitive limitations or swallowing limitations.

We understand the concern that modified food consistency and supervision represent differences in the resident's status, and will take this into consideration as we continue development of these measures.

Major Surgery
Summary: One commenter sought clarification regarding what is considered a major surgery.

Response: Major surgery refers to a procedure requiring general anesthesia. In addition, major surgery usually carries some degree of risk to the patient's life, or the potential for severe disability if something goes wrong during the surgery. A patient would be required to stay at least one overnight in an acute care hospital. This guidance is provided in the IRF-PAI Manual, Section 4 – Quality Indicators - J, which can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-QRP-Manual.html

Primary Medical Condition and Admission Function Interaction
Summary: One commenter requested clarification on how the interaction between primary diagnosis and SNF admission functional status is determined.

Response: In examining the functional outcomes of residents in the SNF setting and patients in the IRF setting, we observed that admission function, primary diagnosis and the interaction of admission function with the primary diagnosis were all significant predictors. Therefore, we included the interaction between primary diagnosis and admission functional status to adjust, in addition to the admission function and primary diagnosis variables, for the effect of admission function scores varying across diagnosis groups.

Additional Risk Adjusters for Consideration for All Measures
Summary: CMS received several recommendations for additional risk adjusters. These recommendations included risk adjustment for a stay of three weeks or more in an acute hospital, as well as consideration of chemotherapy and other intravenous medications, enteral nutrition, use of devices such as durable medical equipment, orthotics/prosthetics and communication devices, complex wound care, respiratory failure, tracheostomy, visual impairment, and hearing impairment. Commenters also recommended additional risk adjusters such as the expression of ideas and wants, the ability to understand others, behavioral signs and symptoms, the Confusion Assessment Method (CAM), and the patient health questionnaire (PHQ). There were also suggestions to include environmental factors such as the availability of community and family support, access to community for basic needs, access to transportation, independent living status, and ability to return to work.

CMS also received recommendations for additional risk adjusters specifically for the self-care quality measures. The commenter indicated that several risk adjusters in the mobility measures should be included in the self-care measures as well. These included several cancer-related risk adjusters including lung and other severe cancers, lymphoma, and other major cancers such as colorectal, bladder, and other cancers, other respiratory and heart neoplasms, other digestive and urinary neoplasms, and other neoplasms. This also included mental health disorders such as schizophrenia, major depressive, bipolar, paranoid, and personality disorders, and reactive and unspecified psychosis. Other risk adjusters included in the mobility measures, and not the self-care measures,

were noted as legally blind, total parenteral nutrition, functional cognition, major fracture (except of skull, vertebrae or hip), and major organ transplant or replacement status or other organ transplant status.

Response: CMS appreciates the commenters' recommendations for additional risk adjusters, and we will take the recommendations into consideration. It should be noted that several of the factors that are suggested are already risk factors that we have found to be statistically significant. A final list of risk adjusters would be selected based on evidence in the literature, stakeholder comments during Technical Expert Panels, public comment opportunities statistical findings, and input from subject matter experts.

1.7 Implementation Issues

Provider Communication

Summary: Several commenters supported education and training for any new items being added to the MDS. Commenters encouraged early and substantial training for facility staff on the items and the measures themselves to ensure meaningful data collection. One commenter suggested CMS provide training to SNF staff that is specifically focused on using ICD-10 codes. Several commenters recommended active and transparent communication with stakeholders as the measures, particularly the risk adjusters, are further refined. One commenter suggested a review of the current training to improve the training offered to SNF providers.

One commenter cautioned that CMS should consider the education level and professional expertise of the clinician when interpreting the data and drawing any conclusions. Another commenter further recommended that dissemination of materials include a minimum competency test.

Response: CMS appreciates the commenters' feedbck and agrees that comprehensive training is needed to ensure accuracy of data collection and interpretation. CMS has previously addressed similar concerns with public outreach including training sessions, training manuals, Webinars, open door forums, help desk support, and a website that hosts training information (http://www.youtube.com/user/CMSHHSgov).

CMS requires that providers submit accurate data to CMS, and CMS provides training and other resources; however, providers need to collect data in a manner that fits with the clinical workflow within their facility. CMS recognizes that each provider may have unique workflow issues, which may mean that data collection protocols are not exactly alike.

Burden

Summary: CMS received several comments about the burden of data collection associated with these new SNF quality measures. Another commenter expressed concern about the implementation costs to the Medicare program for the additional assessment items. This commenter suggested the costs were too high.

Response: We recognize that any new data collection is associated with burden and take such concerns under consideration when developing and selecting quality measures. As CMS develops quality measures, we review existing items and consider the appropriateness of adding or deleting any items. CMS would like to emphasize the importance of standardized functional assessment and

functional status quality measurement. The use of standardized clinical data to describe a patient's status across providers could facilitate communication among providers.

1.8 Penalties Related to Measure Scores

Summary: One commenter expressed concerns regarding the expected score, which is derived from the listed risk adjusters. The commenter was concerned that providers will be financially penalized while CMS is testing and revising risk adjusters.

***Response*:** CMS would like to clarify that the SNF QRP is a pay-for reporting program, and providers are subject to a penalty if they elect not to submit quality data to CMS. Under the SNF QRP, payment is not tied to the results of the quality measures.

1.9 Future Quality Measures

Summary: CMS received several comments on recommendations for the development of future measures of function in the SNF setting. There were generally comments encouraging CMS to develop more robust measures of function. One commenter indicated that these measures are important because measuring quality in functional outcomes highlights the value of physiatrists. Specific ideas for future measures included measures that examine a return to prior functioning, measures of cognition, communication and behavioral functioning, and measures of more complex abilities. Two commenters also recommended assessment of community-oriented factors such as the ability to live independently, community participation, and social interaction once the data elements are standardized across settings.

Response: CMS will take commenters recommendations into consideration as we move to refine and develop new quality measures. We agree that these are very important aspects of resident functioning, and quality measures focused on these aspects of resident functioning are important.

1.10 Other Comments

Summary: CMS received several comments offering suggestion to improve the background and introduction sections for the measures, which included: mentioning the importance of coordinated rehabilitation medical care, revising the wording to better reflect function maintenance as an appropriate outcome in the SNF setting, revising the wording around discharge settings, and revising wording to ensure clarity regarding the population of interest for this measure.

Response: CMS thanks commenters for their suggestions to improve and clarify descriptions of the SNF functional outcome measures.

Suggestions for SNF/Nursing Home Quality Unrelated to the SNF Function Quality Measures

Two comments specifically address Nursing Home compare and SNF payment policies. These comments are valuable to CMS and we have shared them with the appropriate CMS staff. However, these comments are outside the scope of this public comment opportunity.

Preliminary Recommendations

CMS and the measure development contractors appreciate the comments received for the Functional Status Quality Measures for Skilled Nursing Facilities. The general comments about the potential changes to the measures, as well as specific input we received on measure and item alignment, the rating scale, risk adjustment considerations, measure inclusion and exclusion criteria, implementation issues, and other aspects of the measure specifications were informative for continued measure development. Comments noting potential unintended consequences could inform ongoing monitoring and evaluation. As previously stated, measure development is iterative, and CMS reviews the performance of measures and makes revisions to specifications in order to optimize the performance of measures.

To the extent possible, we will incorporate suggestions received through the public comment. Specifically, as we continue development of these measures, we will plan to:

- Continue measure testing and development,
- Continue assessment of reliability and validity of these items and measures, and
- Test additional risk adjusters based on available data.

Overall Analysis of the Comments and Recommendations

The comments and feedback received provided useful input for the refinement of the Functional Status Quality Measures for Skilled Nursing Facilities.

Public Comment Verbatim Report

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
10/13/16	There are many variables that can affect the outcome measures, flu, pneumonia, general downturn of overall health, stroke and so on. If the results of these measures will have an effect on a facilities rating, the uncontrollable variables must be taken into account. The items on change in score from admit to discharge is of no value due to the variety of health occurrences an individual may have that can set them back and are uncontrollable by a facility. The percentages regarding meeting or exceeding have no relationship to anything. If there were experimentation occurring the figures would give indication as to success or failure of the tenants of the experiment. These measures give no indication of quality whatsoever, other than to collect insignificant data. My question is of what value is the data?	Michael D. Van Sickle Chief Operating Officer Bethany Lutheran Home
11/2/16	On behalf of our 93,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments on the Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities. Physical therapy is an integral service provided to Medicare beneficiaries in all post-acute care settings. Physical therapists furnish medically necessary services to patients to improve their overall health and function, and to optimize their quality of life. Across the post-acute care settings, physical therapists provide services to patients through a plan of care that engages and optimizes the patient's participation in achieving shared goals of improved functional performance, reduced risk of injurious falls, and reduced risk of acute hospitalization, thereby promoting long-term health and wellness. Physical therapists perform an examination that includes the patient's history, a systems review, and tests and measures to determine the patient's therapeutic, rehabilitative, and functional status and any environmental factors that may limit the patient's activity and/or restrict participation. Through the evaluative process, the physical therapist develops a comprehensive plan of care to achieve the goals and outcomes of improved function. The physical therapist also instructs patients and caregivers in areas that will help to address specific impairments, activity limitations, participation restrictions, and environmental factors. This may include instruction in the use and performance of therapeutic exercises, functional activities, and assistive or adaptive devices, including prostheses and orthoses. As essential members of the health care team, physical therapists play an integral role in the transition of patients to the community.	Heather Smith, PT, MPH Director of Quality American Physical Therapy Association

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	Comments on the functional measures APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice. Furthermore, APTA believes it is essential that we move toward a core set of functional items to assess patients across the continuum of care. APTA is pleased to see that the inpatient rehabilitation facility (IRF) functional measures also are proposed for the skilled nursing facility (SNF) setting. Additionally, in reviewing the specifications we are pleased to see that the risk-adjustment methodology now includes more variables than were originally released with the specifications for the IRF functional measures. We encourage ongoing evaluation and updating of the risk- adjustment methodologies as is warranted. APTA would like clarification of the risk- adjustment variables. The risk-adjustment variable "functional cognition" is included in the mobility measure, but we are not certain how the data on that variable is being collected. We are also unsure why the "functional cognition" variable is included in the mobility measure risk adjustment and not the self-care risk-adjustment methodology as we believe that functional cognition would impact both mobility and self-care. We encourage transparency and ongoing communication with key stakeholders as quality measures continue to evolve. Last, APTA believes that provider education is important as new data elements are introduced into the post-acute care settings through the implementation of the Improving Medicare Post-Acute Care Transformation Act. We encourage ongoing education efforts for the new items in the SNF setting. Conclusion APTA thanks CMS for the opportunity to comment on the Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities, and we look forward to working with the agency and RTI on these and other quality measures. If you have any questions regarding our comments, please contact Heather Smith, PT, MPH, director of quality, at 703/706-3140 or heathersmith@apta.org.	
11/3/16	The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 186,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech- language pathology support personnel; and students. We appreciate the opportunity to submit comments in response to the document entitled, "Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities." We recognize that these measures are being developed for the purpose of implementing the Improving Post-Acute Care Transformation (IMPACT) Act, which requires standardized assessment items and quality measures across four post-acute care settings. Many of the draft measure specifications are associated with the skills of speech-language pathologists (SLPs) who work in these settings. As such, we believe it is critically important for these detailed specifications to be reflective of the practice of SLPs to ensure that the Centers for Medicare & Medicaid Services (CMS) achieves its ultimate goal of improving the quality of care received by Medicare beneficiaries who are treated in these settings.	Sarah Warren, MA Director, Health Care Regulatory Advocacy American Speech-Language-Hearing Association (ASHA)

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	Our comments focus on the following areas: 1. Encouraging CMS to expand its conception of function beyond self-care and mobility to include communication and cognitive function as well as changes in cognitive function, as required by the IMPACT Act. 2. Ensuring the individual items, and associated scoring methodologies, that are utilized as a proxy for quality are appropriately specified. 3. Recommending refinements to the risk adjustment methodology. **Assessing Cognitive Function and Changes in Cognitive Function are Essential to Improving Quality of Care** In its development of the IMPACT Act, Congress delineated requirements associated with function to include cognitive function and changes in cognitive function. We recognize that CMS has made efforts, through convening technical expert panels and soliciting stakeholder feedback, in order to identify or develop a measure or measures associated with cognitive function. On numerous occasions, ASHA has provided a proposal to CMS in an effort to facilitate the incorporation of such a measure into the assessment tools used by post-acute care settings. We would be remiss if we did not reiterate our desire to see such a measure adopted in an effort to improve the quality of care Medicare beneficiaries receive. ASHA appreciates that "the quality measures described in this document focus on self-care and mobility activities... [that CMS] recognizes that inpatient rehabilitation programs focus on recovery across many areas of function at the level of body structure and function, activities, and participation... [and that] additional research is needed to develop quality measures for other areas of function status." ASHA eagerly awaits news regarding how CMS intends to incorporate communication and cognitive functional status quality measures for skilled nursing facilities (SNFs) and to learn more about ongoing quality measure development and implementation for the CMS SNF Quality Reporting Program relative to communication and cognitive function. **Assessment Items Associated with Self-Care Measures** The draft specifications outline assessment items associated with two self-care measures: (a) one for change in self-care score between admission and discharge and (b) a second measure for a patient's self-care discharge score. One of the items associated with self-care involves eating. We have concerns that—as currently structured—the self-care eating item could lead to confusion of how to score the item, which might skew the data that CMS receives. Eating in the draft specifications is defined as "the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency." It is not clear how the proposed scale will be implemented. Specifically, how would a patient be scored who could manipulate a bolus of food towards the back of the mouth and swallow, but could not feed themselves? Specifically, would that presentation be considered a 2 or 3?	

	2. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds resident's trunk or limbs and provides more than half the effort. *3. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports resident's trunk or limbs, but provides less than half the effort.* Also relative to the eating item, if a patient were tube fed, would that be considered a 1 or 88? *1. Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the task. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.* *88. Not attempted due to medical condition or safety concerns* **Refining the Risk Adjustment Variables** ASHA is providing recommendations for refining the risk adjustment variables related to cognition, communication, and swallowing. Specifically: <u>Cognition</u> In the list of risk adjustment variables for all four measures specified, the BIMS is used as a proxy for cognition (Cognitive abilities: Brief Interview for Mental Status (BIMS) score). This is a misnomer and misleading as short-term memory is only one aspect of cognition. Therefore, we recommend **that this variable be re-titled to "Short-Term Memory: Brief Interview for Mental Status (BIMS) score.** Perhaps once other measures of cognitive function are included, a composite measure could be created that would validly represent patient's cognitive status, but the BIMS score by itself doesn't measure all of cognition; therefore, CMS should try to ensure truthful and transparent communications to health care professionals, insurers, patients and their family, that the BIMS is a measure of short-term memory and that it is not a comprehensive assessment of the patient's cognitive abilities. <u>Communication</u> In the list of risk adjustment variables for the two mobility measures is the communication item: *Communication: Understanding verbal content and expression of ideas and wants* *Moderate to severe communication limitations: Rarely/never understands; or sometimes understands; or rarely/never expresses self; or speech is very difficult to understand; or frequently exhibits difficulty with expression* *Mild to no communication limitations: Usually understands or understands; or some difficulty with expression; or expression without difficulty; or unable to assess or unknown (reference category)* It is assumed that the communication item predicted a significant amount of the variance since it has been included in this list of risk adjustment variables. ASHA has commented about this item many times before because this data element is inadequate. It conflates speech and language and mild problems with no problem at all. People with mild	

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	communication disorders can have significant activity limitations and participation restrictions and by putting them in the same risk adjusted group as people who have normal communication abilities, is to seriously disadvantage these individuals. By condensing all communication disorders, including both speech and language from normal to severe, into just two categories (i.e., Moderate to severe communication limitations and Mild-to-no communication limitations), the importance of communication to the rehabilitation potential of individuals is grossly under-appreciated. **The need for quality data elements that independently address speech and language and can be scaled appropriately for the sensitivity requirements of outcomes measurement are sorely need and eagerly awaited!** Swallowing All four measures include at risk adjustment variables associated with swallowing ability which are broken into a three-part structure for the two self-care measures as delineated below: Swallowing ability Tube/Parenteral feeding Modified food consistency/supervision Regular food/liquids (reference category) Given that patients who need modified food consistencies are not necessarily in need of supervision which is a large expense—but modifying food consistency is not—it is unclear what the rationale was for collapsing these two items. It would be helpful for both risk adjustment and outcomes measurement to separate modified diets from supervision. Otherwise, important rehabilitation gains and shifts in resource utilization will go undetected in cases where a patient—who once required both diet modification and supervision—is later able to feed himself or herself without supervision, but still requires diet modification. Reductions in the need for supervision should be recognized as an important improvement for the patient and the payer, but if the patient still requires diet modification, this improvement would not be reflected in the data. It is for this reason that we are recommending that the swallowing item for the self-care measures be comprised of four categories, as follows: Swallowing ability Tube/Parenteral feeding Supervision Modified food consistency Regular food/liquids (reference category) Further, the instructions for completing this item should note that the maximum level of assistance is to be reported. For example, if the patient is on regular food, but requires supervision, the supervision level should be selected. Lastly, in the section on "Self-Care Items" the word "Eating" is used to describe this category; however, in the list of risk adjustment variables, the term "Swallowing ability" is used. This inconsistent labeling is more than just a matter of semantics. "Eating" is defined as "the ability to use suitable utensils to bring food to the mouth and swallow food once	

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	the meal is presented on a table/tray. Includes modified food consistency." "Eating" is a more inclusive term compared to "swallowing" and since the categories listed under "Swallowing ability" include more than just swallowing ability, we strongly suggest that the term "Eating" be applied as the label for the risk adjustment category as well as in the list of "Self-Care Items". In conclusion, ASHA thanks CMS and RTI's attention to our comments. Please let us know if we can assist CMS in furthering the goal of adopting a cognitive function measure. If you have additional questions, please contact Sarah Warren, MA, ASHA's director of health care regulatory advocacy, at 301-296-5696 or swarren@asha.org.	
11/4/16	On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,600 rehabilitation nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Call for Public Comment regarding the Development of Functional Outcome Quality Measures for Skilled Nursing Facilities (SNFs). Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/SNFs, long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices. Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. We begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness and continue to provide support and care, including patient and family education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses also often teach patients and their caregivers how to access systems and resources. ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive quality care in whichever care setting is most appropriate for them. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for people living with physical disability and/or chronic illness. **ARN Comments and Recommendations** ARN concurs with RTI International that "measuring residents' functional improvement across all SNFs on an ongoing basis would permit identification of SNF characteristics, such as ownership types or locations, associated with better or worse resident outcomes and thus help SNFs optimally target quality improvement efforts."1 In order to accurately evaluate the effectiveness of the rehabilitation care provided to individual residents and the overall effectiveness of the SNF, we also agree with the Technical Expert Panel (TEP) that there should be standardization of functional status	Jordan Wildermuth, MSW Manager, Health Policy & Advocacy ARN

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	and self-care items collected across settings. Further, the addition of such items should align with existing quality measures. ARN believes that measures should reflect the following attributes: a low collection burden for providers and beneficiaries; comprehensibility for beneficiaries; a high level of significance to patients and providers; and data that is routinely captured. Functional measures are not "one size fits all," and they should take into account the benefits of the quality of life domain for all patients, including those with serious or life-threatening conditions. CMS has previously stated that the goal of rehabilitation is to improve function and discharge the patient to the least restrictive setting. If a facility is providing rehabilitation, the goal should be to improve function so that the patient's outcomes can be compared across the post-acute care (PAC) continuum. Risk adjustment is vitally important and should be based on function, age, and impairment/diagnoses. Additionally, the methodology utilized should be the same across PAC settings in order to make valid comparisons across populations or settings. **Conclusion** ARN very much appreciates the opportunity to provide comments to CMS and RTI International in response to the Call for Public Comment on the Development of Functional Outcome Quality Measures for SNFs. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement quality measures that promote access to and evaluation of the quality care for Medicare beneficiaries with physical disabilities and/or chronic disease and frailty. If you have any questions, please contact me or have your staff contact our Health Policy Associate, Kara Gainer (Kara.Gainer@dbr.com or 202-230-5649). We thank you for your consideration of our concerns, recommendations, and requests.	
11/4/16	The American Health Care Association /National Center for Assisted Living (AHCA/NCAL) represents more than 13,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member centers each day. AHCA/NCAL is pleased to have the opportunity to comment on the draft specifications for the skilled nursing facility (SNF) functional status quality measures. Overall, we believe that the proposed measures are moving in a positive direction and we encourage continued development. In the enclosed comments, we outline key areas of support, areas of concern and recommendations to address those areas of concern that we have been able to compile in the comment period provided. We appreciate your responsiveness in extending the comment period from the original October 28 date to November 4. Thank you again for the opportunity to provide these comments. Please contact me at dciolek@ahca.org for questions or additional information.	Daniel E. Ciolek, PT, MS, PMP Associate Vice President, Therapy Advocacy American Health Care Association

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	AHCA/NCAL General Comments AHCA/NCAL have been, and remain strong supporters of the principles and objectives of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and are committed to working with you to see that measures required in the law are implemented as intended. The IMPACT Act established a detailed process through which critically important data and information will be collected, analyzed and synthesized across PAC settings. The thoughtful analysis of these data and appropriate stakeholder engagement in developing meaningful quality and resource use measures could provide the foundation for significant changes to post-acute quality and payment policies aligned with the triple aims of the National Quality Strategy of better care, smarter spending, and healthier people. First, Section 2(a) of the IMPACT Act specifies that post-acute care (PAC) providers, including SNFs are required to submit standardized patient assessment data including, *"Functional status, such as mobility and self care at admission to a PAC provider and before discharge from a PAC provider."* Additionally, this section of the IMPACT Act requires PAC provider reporting of several quality measures including "*Functional status, cognitive function, and changes in cognitive function"* within aggressive statutory timelines. Second, Section 2(b) of the IMPACT Act requires the Secretary to, in consultation with the Medicare Payment Advisory Commission (MedPAC) and appropriate stakeholders (including SNF) to submit a report to Congress on recommendations for a new PAC prospective payment system. This report is to include an evaluation of the new quality measures established in Section 2(a) within two years of data collection onset, and is to include *"…recommendations and a technical prototype, on a post-acute care prospective payment system…and base payments under such title…according to individual characteristics (such as cognitive ability, functional status, and impairments) of such individual…"* As noted in the "Background" and "Appendix References" sections of the draft specifications document, standardized function measures are extremely useful in predicting outcomes and evaluating quality and value of care delivery. AHCA/NCAL strongly agrees with this and of the importance of standardizing the individual functional items measured across all PAC settings. Without such alignment, it will be difficult for the Secretary to achieve the objectives of designing a unified PAC prospective payment system based on resident characteristics as required under the IMPACT Act. While CMS has promulgated regulations within the IMPACT Act timelines to require PAC providers to submit process measures that include some individual items that measure function, we believe it is currently not sufficient. As you can see demonstrated in Table 1 and Table 2 below, only one of 30 current function mobility or self-care items, *"Lying to sitting on side of bed"* is standardized across all PAC settings.	

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	Only 10 of the 30 current function mobility or self-care items (bold text) are used in any current PAC setting-specific quality measures. Additionally, SNF is only currently required to report 17 of the 30 standardized current function mobility or self-care items, and doesn't report any of the important prior function or prior device use items. As you will see in our detailed comments below, AHCA strongly supports the adoption of all applicable mobility and self-care items for public reporting, and that these items reflected in Table 1 and Table 2 are standardized across all PAC settings so that true patient-centered quality measurement and payment models as intended by the IMPACT Act can be established. **Table 1. Current Alignment of Prior Function and Self-Care items Across PAC Settings**	

Section GG Item	Prior Function and Self-Care Items	HH	IRF	SNF	LTCH
		OASIS C2	IRF-PAI 1.4	MDS 3.0	LCDS v3.00
		1/1/17	10/1/16	10/1/16	4/1/16
GG0100	Prior Functioning		X		X
GG0110	Prior Device Use		X		X
GG0130A	**Eating**		**X**	**X**	**X**
GG0130B	**Oral hygiene**		**X**	**X**	**X**
GG0130C	**Toileting hygiene**		**X**	**X**	**X**
GG0130D	Wash upper body				X
GG0130E	Shower/bathe self		X		
GG0130F	Upper body dressing		X		
GG0130G	Lower body dressing		X		
GG0130H	Putting on/taking off footwear		X		

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter

Table 2. Current Alignment of Mobility Items Across PAC Settings

Section GG Item	Mobility Items	OASIS C2 1/1/17	IRF-PAI v1.4 10/1/16	MDS 3.0 10/1/16	LCDS v3.00 4/1/16
GG0170A	Roll left and right		X		X
GG0170B	**Sit to lying**		**X**	**X**	**X**
GG0170C	**Lying to sitting on side of bed**	**X**	**X**	**X**	**X**
GG0170D	**Sit to stand**		**X**	**X**	**X**
GG0170E	**Chair/bed-to-chair transfer**		**X**	**X**	**X**
GG0170F	**Toilet transfer**		**X**	**X**	**X**
GG0170G	Car transfer		X		
GG0170H	Does the patient walk?		X	X	X
GG0170I	Walk 10 feet		X		X
GG0170J	Walk 50 feet with two turns		X	X	X
GG0170K	Walk 150 feet		X	X	X
GG0170L	Walking 10 feet on uneven surface		X		
GG0170M	1 step (curb)		X		
GG0170N	4 steps		X		
GG0170O	12 steps		X		
GG0170P	Picking up object		X		
GG0170Q	*Does patient use a wheelchair/scooter?*		X	X	X
GG0170R	**Wheel 50 feet with two turns**		**X**	**X**	**X**
GG0170RR	*Type of wheelchair/scooter*		X	X	X
GG0170S	**Wheel 150 feet**		**X**	**X**	**X**
GG0170SS	*Type of wheelchair/scooter*		X	X	X

In addition, while we have provided comments specific to each proposed item for each of the four measures in the following pages, we would like to call your attention to specific issues pertaining to *"Exclusions"* and *"Risk Adjustment"* as well as the *"Calculation Algorithm*" in each of the four proposed measures where we have identified concerns and have provided more detailed comments and recommendations.

<u>Exclusions</u>

- Residents who are not Medicare fee-for-service beneficiaries
- Residents who do not have an expectation of functional improvement

<u>Risk Adjustment</u>

- Primary rehabilitation diagnosis
- Cognitive Abilities
- Comorbidities

Calculation Algorithm

- Step(s) on handling *"activity did not occur"* item responses

AHCA/NCAL - Detailed Comments Specific to the Draft
SNF Functional Status Quality Measures Specifications Document

Draft Specifications for the SNF Functional Status Quality Measures for Skilled Nursing Facilities - September 29, 2016 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Development-of-Functional-Outcome-Quality- Measures-for-Skilled-Nursing-Facilities-SNFs-.pdf

May 5, 2016 TEP Summary Report https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/NursingHomeQualityInits/Downloads/SNF-Function-Quality- Measures-TEP-Summary-Report-August-2016.pdf

Section/Item	Comments
	Section 1 - Background
	We note that page 1 paragraph 2 states *"SNFs provide skilled services, such as skilled nursing and therapy services. Residents receiving care in SNFs include those whose illness, injury, or condition has resulted in a loss of function, and for whom rehabilitative care is expected to help regain that function."* We believe that the above statement creates an inaccurate impression that maintenance is not an appropriate expected functional outcome in a SNF. This would contradict most of the remaining discussion in the draft specifications document. **We recommend** the following revision be made to the sentence to better reflect the SNF benefit. *"SNFs provide skilled services, such as skilled nursing and therapy services.* *Residents receiving care in SNFs include those whose illness, injury, or condition has resulted in a loss of function, and many, for whom rehabilitative care is expected to help regain that function."*
	We note that page 2, second paragraph, last sentence appears to be incomplete. **AHCA recommends** that long-term nursing placement be added as a discharge planning option into the sentence. For example – *"The functional status items on the CARE Item Set are daily activities that clinicians typically assess at the time of admission and/or at discharge to determine patients'/residents' needs, evaluate patient/resident progress, and prepare patients/residents and families for a transition to home, ~~or~~ to another setting, or to remain as a long-term nursing facility resident."*
	We note that page 2, fifth paragraph, second sentence contains terminology that could confuse SNF measures with IRF measures. **AHCA recommends** the terminology be revised to make the language consistent with the first two words in paragraph one on page 2. For example – *"We recognize that ~~inpatient~~ rehabilitation programs focus on recovery across many areas of function at the level of body structure and function, activities, and participation; however, additional research is needed to develop quality measures for other areas of function status."*

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Section 2 – Quality Measures		
	2.1 Quality Measure: An Application of IRF Functional Outcome Measure: Change in Self- Care Score for Medical Rehabilitation Patients (NQF #2633)		
	2.1.1 Summary Description	**AHCA supports** the *"Summary Description"* for this proposed measure.	
	2.1.2 Purpose/Rationale for Quality Measure	**AHCA supports** the *"Purpose/Rationale"* for this proposed measure.	
	2.1.3 Population	**AHCA supports** the *"Population"* described for this proposed measure.	
	Quality Measure Exclusions:	---	
	Residents with incomplete stays.	**AHCA supports** the *"Residents with incomplete stays"* exclusion for this proposed measure.	
	Residents who are independent with all self-care activities at the time of admission.	**AHCA supports** the *"Residents who are independent with all self-care activities at the time of admission"* exclusion for this proposed measure.	
	Residents with the following medical conditions:	**AHCA supports** the *"Residents with the following medical conditions"* exclusions listed for this proposed measure.	
	Residents younger than 21 years.	**AHCA supports** the *"Residents younger than 21 years"* exclusions listed for this proposed measure.	
	Residents discharged to hospice.	**AHCA supports** the *"Residents discharged to hospice"* exclusions listed for this proposed measure. **However, we recommend** that this exclusion include an appropriate timeframe after the SNF discharge for the hospice admission (e.g. 7, 14, or 30 days), as the hospice admission may not occur immediately upon SNF discharge.	
	Residents who are not Medicare fee-for-services beneficiaries.	**We recognize** that CMS does not currently require MDS assessment data to be submitted for beneficiaries covered under Medicare Advantage. **However, we are concerned** that, with a growing proportion of Medicare Advantage patients, and with the significant geographic variations in Medicare Advantage market saturation, this measure would only reflect the functional outcomes of a shrinking proportion of Medicare beneficiaries. **We believe** that functional measures can be a very important indicator for SNF quality, but should reflect quality across all payers, or at	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		the very least, all Medicare patients. As such, **we recommend** that any data specifications submitted to CMS from this project include a strong recommendation for CMS to require the submission of admission and discharge MDS assessments for at least Medicare fee-for-service and Medicare Advantage beneficiaries, and that such Medicare Advantage data be incorporated into future iterations of this functional measure.	
	Residents in swing beds in critical access hospitals.	**We recognize** that CMS does not currently require MDS assessment data to be submitted for beneficiaries in swing beds in critical access hospitals. We also recognize that swing bed hospital SNF admissions represent only about 1% of SNF stays, and our data analysis indicates that these patients typically present with conditions that require a much larger proportion of nursing rather than rehabilitation services. As such, unlike our statements about Medicare advantage described above, **AHCA supports** the *"Residents in swing beds in critical access hospitals"* exclusions listed for this proposed measure at this time. **We recommend** that the measure specification recommendations include a statement that CMS should consider reevaluate removing this exclusion at a later date to permit the establishment of patient-centered PAC cross- setting functional measures that would be able to include CAH swing-bed SNF services.	
	Residents who do not have an expectation of functional improvement.	**AHCA supports the intent** of the proposed *"Residents who do not have an expectation of functional improvement"* exclusion listed for this proposed measure as beneficiaries are entitled to SNF services based on the need for skilled nursing or rehabilitative care. The SNF benefit is not contingent on functional improvement. While many beneficiaries are admitted with the expectation of functional improvement, others are admitted with complex or degenerative conditions, other than the specific obvious diagnoses listed in the first measure exclusion listed above, that the physician and the care team have identified as not likely to achieve functional improvements that can be identified by the functional assessment items contained in this proposed measure. This proposed exclusion, if properly developed, could better assure that beneficiaries that are not expected to achieve functional improvements are not included in the denominator for this measure.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		AHCA recommends a more detailed definition be provided for *"Residents who do not have an expectation of functional improvement."* Specifically, Is the intent of this exclusion to include a list of chronic/degenerative conditions based on data analytics that demonstrate little or no functional improvement (e.g. ALS, Parkinson's, Multiple Sclerosis)? Or is the intent of this exclusion to exclude patients whose discharge function goals in Section GG are identical to the admission function? In either case, we believe that those patients identified in these exclusions that present upon admission self-care rating of 2-6 should be included in a separate to-be-developed measure that addresses the prevention of functional loss.	
	2.1.4 Items Included in the Quality Measure	**AHCA is concerned** that Section GG item GG0130D – Wash upper body, is not proposed to be included in this SNF measure. The *"Wash upper body"* item is currently used in Section GG of the LTCH assessment. We believe that it is important to standardize assessments across PAC settings to permit the future development of a PAC cross-setting functional measure. **AHCA recommends** that the *"Wash upper body"* item be added to this quality measure, either as a required item, or as part of "skip" logic.	
	Self-Care Items	---	
	Eating:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Oral hygiene:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Toilet hygiene:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Shower/bathe self:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Upper body dressing:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Lower body dressing:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Putting on/taking off footwear:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Self-Care Rating Scale:	This is an existing SNF MDS Section GG item rating scale and **we support its inclusion** into this proposed measure.	
	2.1.5 Risk Adjustment	**AHCA supports** the *"Risk Adjustment"* introductory language for this proposed measure, and appreciate that the proposed risk adjustment variables reflect TEP process input. **However, a critical factor that could impact functional outcomes is the availability of social support in the discharge environment, especially the availability of competent caregivers (e.g. family, friends) to provide set-up and assistance with functional activities as the individual continues their rehabilitation care plan.** Individuals with available social supports and follow-up home health or outpatient rehabilitation could be appropriately discharged from the SNF sooner and with less observable functional change. In contrast, individuals with limited to no social supports in the home environment would typically be expected to require a more significant functional improvement in the SNF to permit discharge to the home environment. As such, a functional measure that accounts for differences in social support availability in the discharge environment would not penalize providers that are able to effectively transition the individual to a lower cost provider to continue care. We recognize that such an item is not currently available on the SNF MDS or other PAC assessment instruments; however, **we believe it as important a variable as the proposed prior function and prior device use items listed below, and should be added as a reportable item to permit analysis for future risk adjustment purposes.** Below are item specific comments for the proposed risk adjustment items.	
	Age group at SNF admission	**AHCA supports** the *"Age group at SNF admission"* risk adjustment variable for this proposed measure.	
	Admission self-care function score: continuous form	**AHCA supports** the *"Admission self-care function score: continuous form"* risk adjustment variable for this proposed measure as long as the AHCA comments pertaining to the specific item recommendations above are adopted.	
	Admission self-care function score: squared	**AHCA supports** the *"Admission self-care function score: squared form"* risk adjustment variable for this proposed measure as long as the AHCA comments	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	form	pertaining to the specific item recommendations above are adopted.	
	Primary rehabilitation diagnosis	In general, this appears to be a reasonably comprehensive list. We would appreciate seeing a complete mapping of ICD-10 codes to this list. **However, we are very concerned that hip and knee replacement is not differentiated by emergent versus elective surgery, and should not be used as a reference category risk adjustment variable as proposed unless this differentiation is first addressed.** As CMS has reported in recent rulemaking discussions, there are significant cost variations between emergent and elective lower extremity surgery. Specifically, in the Comprehensive Care for Joint Replacement Payment Model (CJR) program final rule (80 Fed. Reg. at 73, 273) CMS discusses this differentiation between elective and emergent joint replacements: Following is an excerpt from the CMS CJR Final Rule: *Our analysis showed that episodes with hip fractures, identified by historical anchor hospitalization claims with an ICD–9–CM hip fracture code as the principal diagnosis, have approximately 70 percent greater historical average episode expenditures than episodes without hip fractures, even for episodes within the same anchor MS–DRG, confirming analyses shared by some commenters that also showed episodes with hip fractures to have significantly greater average expenditures. PHA [partial hip] episodes and emergent episodes had similarly higher historical average expenditures than TKA and THA episodes and non-emergent episodes, respectively. There are clearly patient specific conditions that lead to significant episode expenditure variations, even within the same MS–DRG.* *On the basis of the comments and our further analysis, we agree with commenters that proper risk adjustment is necessary to appropriately incentivize participant hospitals to deliver high quality and efficient care (page 73339).* *In light of the comments and our additional analysis, we will modify our proposed policy to risk stratify, or set different target prices, both for episodes anchored by MS–DRG 469 vs. MS–DRG 470 and for episodes with hip fractures vs. without hip fractures. By adding hip fracture status to our risk stratification approach, we believe we can capture a significant amount of patient-driven*	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		episode expenditure variation (page 73340). While a quality measure in itself does not consider costs of care directly, underlying differences in patient populations that are not adequately identified in the design of a quality measure may misrepresent the quality of care delivered by providers that care for a higher proportion of higher cost emergent lower extremity surgery patients that are clinically different from those receiving elective procedures. **AHCA recommends** that the proposed reference category primary diagnosis group risk adjustment variable *"Hip and knee replacement"* be evaluated to determine whether it should be split into separate emergent versus elective diagnosis groups.	
	Interactions between primary diagnosis and SNF admission functional status	**AHCA supports** the *"Age group at SNF admission"* risk adjustment variable for this proposed measure.	
	Prior Surgery: Major surgery in the past 100 days	**AHCA supports** the *"Prior Surgery: Major surgery in the past 100 days"* risk adjustment variable for this proposed measure.	
	Prior Functioning: self-care	**AHCA supports** the *"Prior Functioning: self-care"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Functioning: indoor ambulation	**AHCA supports** the *"Prior Functioning: indoor ambulation"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Walker use	**AHCA supports** the *"Prior Device Use: Walker use"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Prior Device Use: Wheelchair/scooter	**AHCA supports** the *"Prior Device Use: Wheelchair/scooter"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Mechanical lift	**AHCA supports** the *"Prior Device Use: Mechanical lift"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Orthotics/prosthetics	**AHCA supports** the *"Prior Device Use: Orthotics/prosthetics"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Presence of severe pressure ulcer at admission (Stage 2 pressure ulcer)	**AHCA supports** the *"Presence of severe pressure ulcer at admission (Stage 2 pressure ulcer)"* risk adjustment variable for this proposed measure.	
	Presence of severe pressure ulcer at admission (Stage 3, Stage 4 or Unstageable pressure ulcer)	**AHCA supports** the *"Presence of severe pressure ulcer at admission (Stage 3, Stage 4 or Unstageable pressure ulcer)"* risk adjustment variable for this proposed measure.	
	Cognitive abilities: Brief Interview for Mental Status (BIMS) score	**AHCA supports** the *"Cognitive abilities: Brief Interview for Mental Status (BIMS) score"* risk adjustment variable for this proposed measure. This information is currently available on the SNF MDS and has performed well as a risk-adjustor in an AHCA-developed NQF-endorsed "#2613 CARE: Improvement in Self Care" quality measure. **However, we believe** that other cognition factors that are not captured by BIMS can also play an important role in predicting function and should be considered for future iterations of this measure. Specifically, under a separate CMS project, the RAND corporation is conducting a project titled *"Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data"* which includes a requirement to develop cross-setting patient assessment items related to the domain	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		of cognition. In a recent data specifications document shared for public comment, the contractors presented the following items for consideration: 1) BIMS, 2) Expression of ideas and wants, 3) Ability to understand others: Understanding verbal content, 4) Confusion assessment method (CAM), 5) behavioral signs and symptoms, and 6) Patient health questionnaire (PHQ). **AHCA also believes** there is merit to consider additional cognitive domain assessments when they become available in the public domain.	
	Communication: Understanding verbal content and expression of ideas and wants	**AHCA supports** the *"Communication: Understanding verbal content and expression of ideas and wants"* risk adjustment variable for this proposed measure. **However, we request the exploration** of the concept of using a qualifier or gateway process to assure capture of mode and level of communication such as 1) Mode: verbal or written or gesture or assistive device, and 2) Level: word or sentence or conversational.	
	Bladder incontinence	**AHCA supports** the *"Bladder incontinence"* risk adjustment variable for this proposed measure.	
	Bowel incontinence	**AHCA supports** the *"Bowel incontinence"* risk adjustment variable for this proposed measure.	
	Swallowing ability	**AHCA supports** the *"Swallowing ability"* risk adjustment variable for this proposed measure. **However, we request the exploration** of the concept of using a qualifier or gateway process to assure capture and align with the new Rules of Participation in SNF to give evidence of assessment for PO status, such as: 1) Patient assessed for PO status and treatment recommended, 2) Patient assessed for PO status and no treatment recommended, and 3) Patient to be assessed for potential to return to PO status	
	Comorbidities (hierarchical condition categories):	In general, this appears to be a reasonably comprehensive comorbidities list. **We would appreciate seeing** a complete mapping of ICD-10 codes to this list. **Additionally, AHCA would appreciate** a more detailed description of the source of the comorbidities codes that will be used for calculating the proposed measure as well as the proposed lookback period for including these comorbidities in the measure calculation. For example, will these items be derived from all Medicare claims for a period prior to admission, or from data submitted by the SNF on claims or the MDS?	
	2.1.6 Calculation Algorithm	**AHCA generally supports** the overall *"Calculation Algorithm"* described for this proposed measure. **However, we have three concerns** that we would need to see	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		addressed before we could endorse this approach. **First, we would appreciate a further description of how missing items would be addressed** in the calculation algorithm. **Second, we do not believe that there is sufficient detail explaining how the calculation will address all of the "activity did not occur" data points.** Specifically, step 1 and step 2 of the calculation algorithm only identifies how *"activity not attempted"* values would be handled. We believe that this refers to response *88 – Not attempted due to medical condition or safety concerns*. There is no explanation regarding how the other *two "activity did not occur"* response options *09 – Not applicable* or *07 – Resident refused* would be handled. **AHCA recommends** that this be clarified. **Third, based upon our own experience in developing an NQF-endorsed change-in self-care measure using the same CARE items and definitions, we have concerns with recoding the "activity not attempted" code response "88" to a '1' as described in Steps 1 and 2.** Our statistical analyses of a sample of CARE data demonstrated that recoding these items to a 1 can create a statistically significant difference in the change score calculations. Additionally, recent CMS training emphasizes that, despite the item response terminology for response "88," if something cannot be assessed", providers are to code it activity not attempted and that "clinical inferences" should not be made. **AHCA recommends** that analysis comparing the risk-adjustment measure calculation impacts of recoding versus excluding any or all of the three "activity did not occur" item responses, including the percentage of patient stays impacted, and that these results are shared with stakeholders for comment before advancing this proposed measure.	
	2.2 Quality Measure: An Application of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)		
	2.2.1 Summary Description	**AHCA supports** the *"Summary Description"* for this proposed measure.	
	2.2.2 Purpose/Rationale for Quality Measure	**AHCA supports** the *"Purpose/Rationale"* for this proposed measure.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	2.2.3 Population	**AHCA supports** the *"Population"* described for this proposed measure.	
	Quality Measure Exclusions:	---	
	Residents with incomplete stays.	**AHCA supports** the *"Residents with incomplete stays"* exclusion for this proposed measure.	
	Residents who are independent with all mobility activities at the time of admission.	**AHCA supports** the *"Residents who are independent with all mobility activities at the time of admission"* exclusion for this proposed measure.	
	Residents with the following medical conditions:	**AHCA supports** the *"Residents with the following medical conditions"* exclusions listed for this proposed measure.	
	Residents younger than 21 years.	**AHCA supports** the *"Residents younger than 21 years"* exclusions listed for this proposed measure.	
	Residents discharged to hospice.	**AHCA supports** the *"Residents discharged to hospice"* exclusions listed for this proposed measure. **However, we recommend** that this exclusion include an appropriate timeframe after the SNF discharge for the hospice admission (e.g. 7, 14, or 30 days), as the hospice admission may not occur immediately upon SNF discharge.	
	Residents who are not Medicare fee-for-services beneficiaries.	**We recognize** that CMS does not currently require MDS assessment data to be submitted for beneficiaries covered under Medicare Advantage. **However, we are concerned** that, with a growing proportion of Medicare Advantage patients, and with the significant geographic variations in Medicare Advantage market saturation, this measure would only reflect the functional outcomes of a shrinking proportion of Medicare beneficiaries. **We believe** that functional measures can be a very important indicator for SNF quality, but should reflect quality across all payers, or at the very least, all Medicare patients. **As such, we recommend** that any data specifications submitted to CMS from this project include a strong recommendation for CMS to require the submission of admission and discharge MDS assessments for at least Medicare fee-for-service and Medicare Advantage beneficiaries, and that such Medicare Advantage data be incorporated into future iterations of this functional measure.	
	Residents in swing beds	**We recognize** that CMS does not currently require MDS assessment data to be	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	in critical access hospitals.	submitted for beneficiaries in swing beds in critical access hospitals. We also recognize that swing bed hospital SNF admissions represent only about 1% of SNF stays, and our data analysis indicates that these patients typically present with conditions that require a much larger proportion of nursing rather than rehabilitation services. As such, unlike our statements about Medicare advantage described above, **AHCA supports** *the "Residents in swing beds in critical access hospitals"* exclusions listed for this proposed measure at this time. **We recommend that** the measure specification recommendations include a statement that CMS should consider reevaluate removing this exclusion at a later date to permit the establishment of patient-centered PAC cross- setting functional measures that would be able to include CAH swing-bed SNF services.	
	Residents who do not have an expectation of functional improvement.	**AHCA supports the intent** of the proposed *"Residents who do not have an expectation of functional improvement"* exclusion listed for this proposed measure as beneficiaries are entitled to SNF services based on the need for skilled nursing or rehabilitative care. The SNF benefit is not contingent on functional improvement. While many beneficiaries are admitted with the expectation of functional improvement, others are admitted with complex or degenerative conditions, other than the specific obvious diagnoses listed in the first measure exclusion listed above, that the physician and the care team have identified as not likely to achieve functional improvements that can be identified by the functional assessment items contained in this proposed measure. This proposed exclusion, if properly developed, could better assure that beneficiaries that are not expected to achieve functional improvements are not included in the denominator for this measure. **AHCA recommends** a more detailed definition be provided for *"Residents who do not have an expectation of functional improvement."* Specifically, Is the intent of this exclusion to include a list of chronic/degenerative conditions based on data analytics that demonstrate little or no functional improvement (e.g. ALS, Parkinson's, Multiple Sclerosis)? Or is the intent of this exclusion to exclude patients whose discharge function goals in Section GG are identical to the admission function? In either case, we believe that those patients identified in these exclusions that present upon admission self-care rating of 2-6 should be included in a separate to-be-developed	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		measure that addresses the prevention of functional loss.	
	2.2.4 Items Included in the Quality Measure	**AHCA supports** the inclusion of all of the functional items proposed for this measure. Comments pertaining to individual items are listed below.	
	Mobility Items	---	
	Roll left and right:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF and LTCH item.	
	Sit to lying:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Lying to sitting on side of bed:	This is an existing SNF MDS item in Section GG that also aligns with existing HH, IRF and LTCH items, and **we support its inclusion** into this proposed measure.	
	Sit to stand:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Chair/bed-to-chair transfer:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Toilet transfer:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Car transfer:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Walk 10 feet:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Walk 50 feet with two turns:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Walk 150 feet:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Walking 10 feet on uneven surfaces:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	1 step (curb):	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	4 steps:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		comparable existing IRF item.	
	12 steps:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Picking up object:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Mobility Rating Scale:	This is an existing SNF MDS Section GG item rating scale and **we support its inclusion** into this proposed measure.	
	2.2.5 Risk Adjustment	**AHCA supports** the *"Risk Adjustment"* introductory language for this proposed measure, and appreciate that the proposed risk adjustment variables reflect TEP process input. **However, a critical factor that could impact functional outcomes is the availability of social support in the discharge environment, especially the availability of competent caregivers (e.g. family, friends) to provide set-up and assistance with functional activities as the individual continues their rehabilitation care plan.** Individuals with available social supports and follow-up home health or outpatient rehabilitation could be appropriately discharged from the SNF sooner and with less observable functional change. In contrast, individuals with limited to no social supports in the home environment would typically be expected to require a more significant functional improvement in the SNF to permit discharge to the home environment. As such, a functional measure that accounts for differences in social support availability in the discharge environment would not penalize providers that are able to effectively transition the individual to a lower cost provider to continue care. We recognize that such an item is not currently available on the SNF MDS or other PAC assessment instruments; however, **we believe it as important a variable as the proposed prior function and prior device use items listed below, and should be added as a reportable item to permit analysis for future risk adjustment purposes.** Below are item specific comments for the proposed risk adjustment items.	
	Age group at SNF admission	**AHCA supports** the *"Age group at SNF admission"* risk adjustment variable for this proposed measure.	
	Admission mobility function score:	**AHCA supports** the *"Admission mobility function score: continuous score"* risk adjustment variable for this proposed measure as long as the AHCA comments	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	continuous score	pertaining to the specific item recommendations above are adopted.	
	Admission mobility function score: squared form	**AHCA supports** the *"Admission mobility function score: squared form"* risk adjustment variable for this proposed measure as long as the AHCA comments pertaining to the specific item recommendations above are adopted.	
	Primary SNF rehabilitation diagnosis	In general, this appears to be a reasonably comprehensive list. We would appreciate seeing a complete mapping of ICD-10 codes to this list. **However, we are very concerned that hip and knee replacement is not differentiated by emergent versus elective surgery, and should not be used as a reference category risk adjustment variable as proposed unless this differentiation is first addressed.** As CMS has reported in recent rulemaking discussions, there are significant cost variations between emergent and elective lower extremity surgery. Specifically, in the Comprehensive Care for Joint Replacement Payment Model (CJR) program final rule (80 Fed. Reg. at 73, 273) CMS discusses this differentiation between elective and emergent joint replacements: Following is an excerpt from the CMS CJR Final Rule. *Our analysis showed that episodes with hip fractures, identified by historical anchor hospitalization claims with an ICD–9–CM hip fracture code as the principal diagnosis, have approximately 70 percent greater historical average episode expenditures than episodes without hip fractures, even for episodes within the same anchor MS–DRG, confirming analyses shared by some commenters that also showed episodes with hip fractures to have significantly greater average expenditures. PHA [partial hip] episodes and emergent episodes had similarly higher historical average expenditures than TKA and THA episodes and non-emergent episodes, respectively. There are clearly patient specific conditions that lead to significant episode expenditure variations, even within the same MS–DRG.* *On the basis of the comments and our further analysis, we agree with commenters that proper risk adjustment is necessary to appropriately incentivize participant hospitals to deliver high quality and efficient care (page 73339).* *In light of the comments and our additional analysis, we will modify our proposed policy to risk stratify, or set different target prices, both for episodes anchored by MS–DRG 469 vs. MS–DRG 470 and for episodes with hip fractures vs. without hip*	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		fractures. By adding hip fracture status to our risk stratification approach, we believe we can capture a significant amount of patient-driven episode expenditure variation (page 73340). While a quality measure in itself does not consider costs of care directly, underlying differences in patient populations that are not adequately identified in the design of a quality measure may misrepresent the quality of care delivered by providers that care for a higher proportion of higher cost emergent lower extremity surgery patients that are clinically different from those receiving elective procedures. **AHCA recommends** that the proposed reference category primary diagnosis group risk adjustment variable *"Hip and knee replacement"* be evaluated to determine whether it should be split into separate emergent versus elective diagnosis groups.	
	Interaction of admission mobility score and primary diagnosis group	**AHCA supports** the *"Interaction of admission mobility score and primary diagnosis group"* risk adjustment variable for this proposed measure.	
	Prior Surgery: Major surgery in the past 100 days	**AHCA supports** the *"Prior Surgery: Major surgery in the past 100 days"* risk adjustment variable for this proposed measure.	
	Prior Functioning: Indoor Mobility (ambulation)	**AHCA supports** the *"Prior Functioning: indoor ambulation"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Functioning: Stairs	**AHCA supports** the *"Prior Functioning: indoor ambulation"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Functioning: Functional Cognition	**AHCA supports** the *"Prior Functioning: Functional Cognition"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Walker	**AHCA supports** the *"Prior Device Use: Walker use"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Wheelchair/scooter	**AHCA supports** the *"Prior Device Use: Wheelchair/scooter"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Mechanical lift	**AHCA supports** the *"Prior Device Use: Mechanical lift"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Orthotics/prosthetics	**AHCA supports** the *"Prior Device Use: Orthotics/prosthetics"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Communication Impairment:	**AHCA supports** the *"Communication Impairment"* risk adjustment variable for this proposed measure.	
	Cognitive abilities: Brief Interview for Mental Status (BIMS) score:	**AHCA supports** the *"Cognitive abilities: Brief Interview for Mental Status (BIMS) score"* risk adjustment variable for this proposed measure. This information is currently available on the SNF MDS and has performed well as a risk-adjustor in an AHCA-developed NQF-endorsed "#2612 CARE: Improvement in Mobility" quality measure. **However, we believe** that other cognition factors that are not captured by BIMS can also play an important role in predicting function and should be considered for future iterations of this measure. Specifically, under a separate CMS project, the RAND corporation is conducting a project titled *"Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data"* which includes a requirement to develop cross-setting patient assessment items related to the domain of cognition. In a recent data specifications document shared for public comment,	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		the contractors presented the following items for consideration: 1) BIMS, 2) Expression of ideas and wants (addressed in item above), 3) Ability to understand others: Understanding verbal content, 4) Confusion assessment method (CAM), 5) behavioral signs and symptoms, and 6) Patient health questionnaire (PHQ). **AHCA also believes** there is merit to consider additional cognitive domain assessments when they become available in the public domain.	
	Bladder incontinence	**AHCA supports** the *"Bladder incontinence"* risk adjustment variable for this proposed measure.	
	Bowel incontinence	**AHCA supports** the *"Bowel incontinence"* risk adjustment variable for this proposed measure.	
	Presence of stage 2 pressure ulcer at admission	**AHCA supports** the *"Presence of stage 2 pressure ulcer at admission"* risk adjustment variable for this proposed measure.	
	Presence of severe pressure ulcer at admission (Stage 3, Stage 4, or Unstageable pressure ulcer)	**AHCA supports** the *"Presence of severe pressure ulcer at admission (Stage 3, Stage 4, or Unstageable pressure ulcer)"* risk adjustment variable for this proposed measure.	
	Swallowing ability:	**AHCA supports** the *"Swallowing ability"* risk adjustment variable for this proposed measure. **However, we request the exploration** of the concept of using a qualifier or gateway process to assure capture and align with the new Rules of Participation in SNF to give evidence of assessment for PO status, such as: 1) Patient assessed for PO status and treatment recommended, 2) Patient assessed for PO status and no treatment recommended, and 3) Patient to be assessed for potential to return to PO status	
	Total parenteral nutrition treatment	**AHCA supports** the *"Total parenteral nutrition treatment"* risk adjustment variable for this proposed measure.	
	History of falls in the past year:	**AHCA supports** *the "History of falls in the past year"* risk adjustment variable for this proposed measure.	
	Comorbidities (hierarchical condition categories):	In general, this appears to be a reasonably comprehensive comorbidities list. **We would appreciate seeing** a complete mapping of ICD-10 codes to this list. **Additionally, AHCA would appreciate** a more detailed description of the source of the comorbidities codes that will be used for calculating the proposed measure as well as the proposed lookback period for including these comorbidities in the measure calculation. For example, will these items be derived from all Medicare claims for a	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		period prior to admission, or from data submitted by the SNF on claims or the MDS?	
	2.2.6 Calculation Algorithm	**AHCA generally supports** the overall *"Calculation Algorithm"* described for this proposed measure. **However, we have three concerns** that we would need to see addressed before we could endorse this approach. **First, we would appreciate a further description of how missing items would be addressed** in the calculation algorithm. **Second, we do not believe that there is sufficient detail explaining how the calculation will address all of the "activity did not occur" data points.** Specifically, step 1 and step 2 of the calculation algorithm only identifies how *"activity not attempted"* values would be handled. We believe that this refers to response *88 – Not attempted due to medical condition or safety concerns*. There is no explanation regarding how the other *two "activity did not occur"* response options *09 – Not applicable* or *07 – Resident refused* would be handled. **AHCA recommends** that this be clarified. **Third, based upon our own experience in developing an NQF-endorsed change-in mobility measure using the same CARE items and definitions, we have concerns with recoding the "activity not attempted" code response "88" to a '1' as described in Steps 1 and 2.** Our statistical analyses of a sample of CARE data demonstrated that recoding these items to a 1 can create a statistically significant difference in the change score calculations. Additionally, recent CMS training emphasizes that, despite the item response terminology for response "88," if something cannot be assessed", providers are to code it activity not attempted and that "clinical inferences" should not be made. **AHCA recommends** that analysis comparing the risk-adjustment measure calculation impacts of recoding versus excluding any or all of the three "activity did not occur" item responses be performed, including the percentage of patient stays impacted, and that these results are shared with stakeholders for comment before advancing this proposed measure.	
	2.3 Quality Measure: An Application of the IRF Functional Outcome Measure: Discharge Self- Care Score for Medical Rehabilitation Patients (NQF #2635)		
	2.3.1 Summary Description	**AHCA supports** the *"Summary Description"* for this proposed measure.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	2.3.2 Purpose/Rationale for Quality Measure	**AHCA supports** the *"Purpose/Rationale"* for this proposed measure.	
	2.3.3 Population	**AHCA supports** the *"Population"* described for this proposed measure.	
	Quality Measure Exclusions:	---	
	Residents with incomplete stays.	**AHCA supports** the *"Residents with incomplete stays"* exclusion for this proposed measure.	
	Residents with the following medical conditions:	**AHCA supports** the *"Residents with the following medical conditions"* exclusions listed for this proposed measure.	
	Residents younger than 21 years.	**AHCA supports** the *"Residents younger than 21 years"* exclusions listed for this proposed measure.	
	Residents discharged to hospice.	**AHCA supports** the *"Residents discharged to hospice"* exclusions listed for this proposed measure. **However, we recommend** that this exclusion include an appropriate timeframe after the SNF discharge for the hospice admission (e.g. 7, 14, or 30 days), as the hospice admission may not occur immediately upon SNF discharge.	
	Residents who are not Medicare fee-for-services beneficiaries.	**We recognize** that CMS does not currently require MDS assessment data to be submitted for beneficiaries covered under Medicare Advantage. **However, we are concerned** that, with a growing proportion of Medicare Advantage patients, and with the significant geographic variations in Medicare Advantage market saturation, this measure would only reflect the functional outcomes of a shrinking proportion of Medicare beneficiaries. **We believe** that functional measures can be a very important indicator for SNF quality, but should reflect quality across all payers, or at the very least, all Medicare patients. As such, **we recommend** that any data specifications submitted to CMS from this project include a strong recommendation for CMS to require the submission of admission and discharge MDS assessments for at least Medicare fee-for-service and Medicare Advantage beneficiaries, and that such Medicare Advantage data be incorporated into future iterations of this functional measure.	
	Residents in swing beds in critical access	**We recognize** that CMS does not currently require MDS assessment data to be submitted for beneficiaries in swing beds in critical access hospitals. We also	

Date Posted		Text of Comments		Name Credentials, and Organization of Commenter
		hospitals.	recognize that swing bed hospital SNF admissions represent only about 1% of SNF stays, and our data analysis indicates that these patients typically present with conditions that require a much larger proportion of nursing rather than rehabilitation services. As such, unlike our statements about Medicare advantage described above, **AHCA supports** the *"Residents in swing beds in critical access hospitals"* exclusions listed for this proposed measure at this time. **We recommend** that the measure specification recommendations include a statement that CMS should consider reevaluate removing this exclusion at a later date to permit the establishment of patient-centered PAC cross- setting functional measures that would be able to include CAH swing-bed SNF services.	
		Residents who do not have an expectation of functional improvement.	**AHCA supports the intent** of the proposed *"Residents who do not have an expectation of functional improvement"* exclusion listed for this proposed measure as beneficiaries are entitled to SNF services based on the need for skilled nursing or rehabilitative care. The SNF benefit is not contingent on functional improvement. While many beneficiaries are admitted with the expectation of functional improvement, others are admitted with complex or degenerative conditions, other than the specific obvious diagnoses listed in the first measure exclusion listed above, that the physician and the care team have identified as not likely to achieve functional improvements that can be identified by the functional assessment items contained in this proposed measure. This proposed exclusion, if properly developed, could better assure that beneficiaries that are not expected to achieve functional improvements are not included in the denominator for this measure. **AHCA recommends** a more detailed definition be provided for *"Residents who do not have an expectation of functional improvement."* Specifically, Is the intent of this exclusion to include a list of chronic/degenerative conditions based on data analytics that demonstrate little or no functional improvement (e.g. ALS, Parkinson's, Multiple Sclerosis)? Or is the intent of this exclusion to exclude patients whose discharge function goals in Section GG are identical to the admission function? In either case, we believe that those patients identified in these exclusions that present upon admission self-care rating of 2-6 should be included in a separate to-be-developed	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		measure that addresses the prevention of functional loss.	
	2.3.4 Items Included in the Quality Measure	**AHCA is concerned** that Section GG item GG0130D – Wash upper body, is not proposed to be included in this SNF measure. The *"Wash upper body"* item is currently used in Section GG of the LTCH assessment. We believe that it is important to standardize assessments across PAC settings to permit the future development of a PAC cross-setting functional measure. **AHCA recommends** that the *"Wash upper body"* item be added to this quality measure, either as a required item, or as part of "skip" logic.	
	Self-Care Items	---	
	Eating:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Oral hygiene:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Toilet hygiene:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Shower/bathe self:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Upper body dressing:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Lower body dressing:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Putting on/taking off footwear:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Self-Care Rating Scale:	This is an existing SNF MDS Section GG item rating scale and **we support its inclusion** into this proposed measure.	
	2.3.5 Risk Adjustment	**AHCA supports** the *"Risk Adjustment"* introductory language for this proposed measure, and appreciate that the proposed risk adjustment variables reflect TEP process input.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		However, a critical factor that could impact functional outcomes is the availability of social support in the discharge environment, especially the availability of competent caregivers (e.g. family, friends) to provide set-up and assistance with functional activities as the individual continues their rehabilitation care plan. Individuals with available social supports and follow-up home health or outpatient rehabilitation could be appropriately discharged from the SNF sooner and with less observable functional change. In contrast, individuals with limited to no social supports in the home environment would typically be expected to require a more significant functional improvement in the SNF to permit discharge to the home environment. As such, a functional measure that accounts for differences in social support availability in the discharge environment would not penalize providers that are able to effectively transition the individual to a lower cost provider to continue care. We recognize that such an item is not currently available on the SNF MDS or other PAC assessment instruments; however, **we believe it as important a variable as the proposed prior function and prior device use items listed below, and should be added as a reportable item to permit analysis for future risk adjustment purposes.** Below are item specific comments for the proposed risk adjustment items.	
	Age group at SNF admission	**AHCA supports** the *"Age group at SNF admission"* risk adjustment variable for this proposed measure.	
	Admission self-care function score: continuous form	**AHCA supports** the *"Admission self-care function score: continuous form"* risk adjustment variable for this proposed measure as long as the AHCA comments pertaining to the specific item recommendations above are adopted.	
	Admission self-care function score: squared form	**AHCA supports** the *"Admission self-care function score: squared form"* risk adjustment variable for this proposed measure as long as the AHCA comments pertaining to the specific item recommendations above are adopted.	
	Primary rehabilitation diagnosis	In general, this appears to be a reasonably comprehensive list. We would appreciate seeing a complete mapping of ICD-10 codes to this list. **However, we are very concerned that hip and knee replacement is not**	

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	differentiated by emergent versus elective surgery, and should not be used as a risk adjustment variable reference category as proposed unless this differentiation is first addressed. As CMS has reported in recent rulemaking discussions, there are significant cost variations between emergent and elective lower extremity surgery. Specifically, in the Comprehensive Care for Joint Replacement Payment Model (CJR) program final rule (80 Fed. Reg. at 73, 273) CMS discusses this differentiation between elective and emergent joint replacements: Following is an excerpt from the CMS CJR Final Rule: *Our analysis showed that episodes with hip fractures, identified by historical anchor hospitalization claims with an ICD–9–CM hip fracture code as the principal diagnosis, have approximately 70 percent greater historical average episode expenditures than episodes without hip fractures, even for episodes within the same anchor MS–DRG, confirming analyses shared by some commenters that also showed episodes with hip fractures to have significantly greater average expenditures. PHA [partial hip] episodes and emergent episodes had similarly higher historical average expenditures than TKA and THA episodes and non-emergent episodes, respectively. There are clearly patient specific conditions that lead to significant episode expenditure variations, even within the same MS–DRG.* *On the basis of the comments and our further analysis, we agree with commenters that proper risk adjustment is necessary to appropriately incentivize participant hospitals to deliver high quality and efficient care (page 73339).* *In light of the comments and our additional analysis, we will modify our proposed policy to risk stratify, or set different target prices, both for episodes anchored by MS–DRG 469 vs. MS–DRG 470 and for episodes with hip fractures vs. without hip fractures. By adding hip fracture status to our risk stratification approach, we believe we can capture a significant amount of patient-driven episode expenditure variation (page 73340).*	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		While a quality measure in itself does not consider costs of care directly, underlying differences in patient populations that are not adequately identified in the design of a quality measure may misrepresent the quality of care delivered by providers that care for a higher proportion of higher cost emergent lower extremity surgery patients that are clinically different from those receiving elective procedures. **AHCA recommends** that the proposed reference category primary diagnosis group risk adjustment variable "Hip and knee replacement" be evaluated to determine whether it should be split into separate emergent versus elective diagnosis groups.	
	Interactions between primary diagnosis and SNF admission functional status	**AHCA supports** the *"Interactions between primary diagnosis and SNF admission functional status"* risk adjustment variable for this proposed measure.	
	Prior Surgery: Major surgery in the past 100 days	**AHCA supports** the *"Prior Surgery: Major surgery in the past 100 days"* risk adjustment variable for this proposed measure.	
	Prior Functioning: self-care	**AHCA supports** the *"Prior Functioning: self-care"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Functioning: indoor ambulation	**AHCA supports** the *"Prior Functioning: indoor ambulation"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Walker	**AHCA supports** the *"Prior Device Use: Walker use"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Prior Device Use: Wheelchair/scooter	**AHCA supports** the *"Prior Device Use: Wheelchair/scooter"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Mechanical lift	**AHCA supports** the *"Prior Device Use: Mechanical lift"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Orthotics/prosthetics	**AHCA supports** the *"Prior Device Use: Orthotics/prosthetics"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Presence of stage 2 pressure ulcer at admission	**AHCA supports** the *"Presence of stage 2 pressure ulcer at admission"* risk adjustment variable for this proposed measure.	
	Presence of severe pressure ulcer at admission (Stage 3, Stage 4 or Unstageable pressure ulcer)	**AHCA supports** the *"Presence of severe pressure ulcer at admission (Stage 3, Stage 4 or Unstageable pressure ulcer)"* risk adjustment variable for this proposed measure.	
	Cognitive abilities: Brief Interview for Mental Status (BIMS) score	**AHCA supports** the *"Cognitive abilities: Brief Interview for Mental Status (BIMS) score"* risk adjustment variable for this proposed measure. This information is currently available on the SNF MDS and has performed well as a risk-adjustor in an AHCA-developed NQF-endorsed "#2613 CARE: Improvement in Self Care" quality measure. **However, we believe** that other cognition factors that are not captured by BIMS can also play an important role in predicting function and should be considered for future iterations of this measure. Specifically, under a separate CMS project, the RAND corporation is conducting a project titled *"Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data"* which includes a requirement to develop cross-setting patient assessment items related to the domain of cognition. In a recent data specifications document shared for public comment,	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		the contractors presented the following items for consideration: 1) BIMS, 2) Expression of ideas and wants, 3) Ability to understand others: Understanding verbal content, 4) Confusion assessment method (CAM), 5) behavioral signs and symptoms, and 6) Patient health questionnaire (PHQ). **AHCA also believes** there is merit to consider additional cognitive domain assessments when they become available in the public domain.	
	Communication: Understanding verbal content and expression of ideas and wants	**AHCA supports** the *"Communication: Understanding verbal content and expression of ideas and wants"* risk adjustment variable for this proposed measure. **However, we request the exploration** of the concept of using a qualifier or gateway process to assure capture of mode and level of communication such as 1) Mode: verbal or written or gesture or assistive device, and 2) Level: word or sentence or conversational.	
	Bladder incontinence	**AHCA supports** the *"Bladder incontinence"* risk adjustment variable for this proposed measure.	
	Bowel incontinence	**AHCA supports** the *"Bowel incontinence"* risk adjustment variable for this proposed measure.	
	Swallowing ability	**AHCA supports** the *"Swallowing ability"* risk adjustment variable for this proposed measure. **However, we request the exploration** of the concept of using a qualifier or gateway process to assure capture and align with the new Rules of Participation in SNF to give evidence of assessment for PO status, such as: 1) Patient assessed for PO status and treatment recommended, 2) Patient assessed for PO status and no treatment recommended, and 3) Patient to be assessed for potential to return to PO status	
	Comorbidities (hierarchical condition categories):	In general, this appears to be a reasonably comprehensive comorbidities list. **We would appreciate seeing** a complete mapping of ICD-10 codes to this list. **Additionally, AHCA would appreciate** a more detailed description of the source of the comorbidities codes that will be used for calculating the proposed measure as well as the proposed lookback period for including these comorbidities in the measure calculation. For example, will these items be derived from all Medicare claims for a period prior to admission, or from data submitted by the SNF on claims or the MDS?	
	2.3.6 Calculation Algorithm	**AHCA generally supports** the overall *"Calculation Algorithm"* described for this proposed measure. **However, we have three concerns** that we would need to see addressed before we could endorse this approach.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		First, we would appreciate a further description of how missing items would be addressed in the calculation algorithm. **Second, we do not believe that there is sufficient detail explaining how the calculation will address all of the "activity did not occur" data points.** Specifically, step 1 of the calculation algorithm only identifies how *"activity not attempted"* values would be handled. We believe that this refers to response *88 – Not attempted due to medical condition or safety concerns*. There is no explanation regarding how the other *two "activity did not occur"* response options *09 – Not applicable* or *07 – Resident refused* would be handled. **AHCA recommends** that this be clarified. **Third, based upon our own experience in developing an NQF-endorsed self-care measure using the same CARE items and definitions, we have concerns with recoding the "activity not attempted" code response "88" to a '1' as described in Step 1.** Our statistical analyses of a sample of CARE data demonstrated that recoding these items to a 1 can create a statistically significant difference in the discharge score calculations. Additionally, recent CMS training emphasizes that, despite the item response terminology for response "88," if something cannot be assessed", providers are to code it activity not attempted and that "clinical inferences" should not be made. **AHCA recommends** that analysis comparing the risk- adjustment measure calculation impacts of recoding versus excluding any or all of the three "activity did not occur" item responses, including the percentage of patient stays impacted, and that these results are shared with stakeholders for comment before advancing this proposed measure.	
	2.4 Quality Measure: An Application of the IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)		
	2.4.1 Summary Description	**AHCA supports** the *"Summary Description"* for this proposed measure.	
	2.4.2 Purpose/Rationale for	**AHCA supports** the *"Purpose/Rationale"* for this proposed measure.	
	2.4.3 Population	**AHCA supports** the *"Population"* described for this proposed measure.	
	Quality Measure Exclusions:	---	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Residents with incomplete stays.	**AHCA supports** the *"Residents with incomplete stays"* exclusion for this proposed measure.	
	Residents with the following medical conditions:	**AHCA supports** the *"Residents with the following medical conditions"* exclusions listed for this proposed measure.	
	Residents younger than 21 years.	**AHCA supports** the *"Residents younger than 21 years"* exclusions listed for this proposed measure.	
	Residents discharged to hospice.	**AHCA supports** the *"Residents discharged to hospice"* exclusions listed for this proposed measure. **However, we recommend** that this exclusion include an appropriate timeframe after the SNF discharge for the hospice admission (e.g. 7, 14, or 30 days), as the hospice admission may not occur immediately upon SNF discharge.	
	Residents who are not Medicare fee-for-services beneficiaries.	**We recognize** that CMS does not currently require MDS assessment data to be submitted for beneficiaries covered under Medicare Advantage. **However, we are concerned that**, with a growing proportion of Medicare Advantage patients, and with the significant geographic variations in Medicare Advantage market saturation, this measure would only reflect the functional outcomes of a shrinking proportion of Medicare beneficiaries. **We believe** that functional measures can be a very important indicator for SNF quality, but should reflect quality across all payers, or at the very least, all Medicare patients. **As such, we recommend** that any data specifications submitted to CMS from this project include a strong recommendation for CMS to require the submission of admission and discharge MDS assessments for at least Medicare fee-for-service and Medicare Advantage beneficiaries, and that such Medicare Advantage data be incorporated into future iterations of this functional measure.	
	Residents in swing beds in critical access hospitals.	**We recognize** that CMS does not currently require MDS assessment data to be submitted for beneficiaries in swing beds in critical access hospitals. We also recognize that swing bed hospital SNF admissions represent only about 1% of SNF stays, and our data analysis indicates that these patients typically present with conditions that require a much larger proportion of nursing rather than rehabilitation services. As such, unlike our statements about Medicare advantage described above, **AHCA**	

Date Posted		Text of Comments		Name Credentials, and Organization of Commenter
			supports the *"Residents in swing beds in critical access hospitals"* exclusions listed for this proposed measure at this time. **We recommend** that the measure specification recommendations include a statement that CMS should consider reevaluate removing this exclusion at a later date to permit the establishment of patient-centered PAC cross- setting functional measures that would be able to include CAH swing-bed SNF services.	
		Residents who do not have an expectation of functional improvement.	**AHCA supports the intent** of the proposed *"Residents who do not have an expectation of functional improvement"* exclusion listed for this proposed measure as beneficiaries are entitled to SNF services based on the need for skilled nursing or rehabilitative care. The SNF benefit is not contingent on functional improvement. While many beneficiaries are admitted with the expectation of functional improvement, others are admitted with complex or degenerative conditions, other than the specific obvious diagnoses listed in the first measure exclusion listed above, that the physician and the care team have identified as not likely to achieve functional improvements that can be identified by the functional assessment items contained in this proposed measure. This proposed exclusion, if properly developed, could better assure that beneficiaries that are not expected to achieve functional improvements are not included in the denominator for this measure. **AHCA recommends** a more detailed definition be provided for *"Residents who do not have an expectation of functional improvement."* Specifically, Is the intent of this exclusion to include a list of chronic/degenerative conditions based on data analytics that demonstrate little or no functional improvement (e.g. ALS, Parkinson's, Multiple Sclerosis)? Or is the intent of this exclusion to exclude patients whose discharge function goals in Section GG are identical to the admission function? In either case, we believe that those patients identified in these exclusions that present upon admission self-care rating of 2-6 should be included in a separate to-be-developed measure that addresses the prevention of functional loss.	
		2.4.4 Items Included in the Quality Measure	**AHCA supports** the inclusion of all of the functional items proposed for this measure. Comments pertaining to individual items are listed below.	
		Mobility Items	---	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Roll left and right:	This is not an existing SNF MDS Item in Section GG; however, we **support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF and LTCH item.	
	Sit to lying:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Lying to sitting on side of bed:	This is an existing SNF MDS item in Section GG that also aligns with existing HH, IRF and LTCH items, and **we support its inclusion** into this proposed measure.	
	Sit to stand:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Chair/bed-to-chair transfer:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Toilet transfer:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Car transfer:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Walk 10 feet:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Walk 50 feet with two turns:	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Walk 150 feet (45 m):	This is an existing SNF MDS item in Section GG that also aligns with existing IRF and LTCH items and **we support its inclusion** into this proposed measure.	
	Walking 10 feet on uneven surfaces:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	1 step (curb):	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	4 steps:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	12 steps:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		with a comparable existing IRF item.	
	Picking up object:	This is not an existing SNF MDS Item in Section GG; however, **we support its adoption** for the MDS, and its inclusion in this proposed measure, so that it aligns with a comparable existing IRF item.	
	Mobility Rating Scale:	This is an existing SNF MDS Section GG item rating scale and **we support its inclusion** into this proposed measure.	
	2.4.5 Risk Adjustment	**AHCA supports** the *"Risk Adjustment"* introductory language for this proposed measure, and appreciate that the proposed risk adjustment variables reflect TEP process input. **However, a critical factor that could impact functional outcomes is the availability of social support in the discharge environment, especially the availability of competent caregivers (e.g. family, friends) to provide set-up and assistance with functional activities as the individual continues their rehabilitation care plan.** Individuals with available social supports and follow-up home health or outpatient rehabilitation could be appropriately discharged from the SNF sooner and with less observable functional change. In contrast, individuals with limited to no social supports in the home environment would typically be expected to require a more significant functional improvement in the SNF to permit discharge to the home environment. As such, a functional measure that accounts for differences in social support availability in the discharge environment would not penalize providers that are able to effectively transition the individual to a lower cost provider to continue care. We recognize that such an item is not currently available on the SNF MDS or other PAC assessment instruments; however, **we believe it as important a variable as the proposed prior function and prior device use items listed below, and should be added as a reportable item to permit analysis for future risk adjustment purposes.** Below are item specific comments for the proposed risk adjustment items.	
	Age group at SNF admission	**AHCA supports** the *"Age group at SNF admission"* risk adjustment variable for this proposed measure.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Admission mobility function score: continuous score	**AHCA supports** the *"Admission mobility function score: continuous score"* risk adjustment variable for this proposed measure as long as the AHCA comments pertaining to the specific item recommendations above are adopted.	
	Admission mobility function score: squared form	**AHCA supports** the *"Admission mobility function score: squared form"* risk adjustment variable for this proposed measure as long as the AHCA comments pertaining to the specific item recommendations above are adopted.	
	Primary SNF Diagnosis Groups:	In general, this appears to be a reasonably comprehensive list. We would appreciate seeing a complete mapping of ICD-10 codes to this list. **However, we are very concerned that hip and knee replacement is not differentiated by emergent versus elective surgery, and should not be used as a reference category risk adjustment variable as proposed unless this differentiation is first addressed.** As CMS has reported in recent rulemaking discussions, there are significant cost variations between emergent and elective lower extremity surgery. Specifically, in the Comprehensive Care for Joint Replacement Payment Model (CJR) program final rule (80 Fed. Reg. at 73, 273) CMS discusses this differentiation between elective and emergent joint replacements: Following is an excerpt from the CMS CJR Final Rule: *Our analysis showed that episodes with hip fractures, identified by historical anchor hospitalization claims with an ICD–9–CM hip fracture code as the principal diagnosis, have approximately 70 percent greater historical average episode expenditures than episodes without hip fractures, even for episodes within the same anchor MS–DRG, confirming analyses shared by some commenters that also showed episodes with hip fractures to have significantly greater average expenditures. PHA [partial hip] episodes and emergent episodes had similarly higher historical average expenditures than TKA and THA episodes and non-emergent episodes, respectively. There are clearly patient specific conditions that lead to significant episode expenditure variations, even within the same MS–DRG.* *On the basis of the comments and our further analysis, we agree with commenters that proper risk adjustment is necessary to appropriately incentivize*	

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		participant hospitals to deliver high quality and efficient care (page 73339). *In light of the comments and our additional analysis, we will modify our proposed policy to risk stratify, or set different target prices, both for episodes anchored by MS–DRG 469 vs. MS–DRG 470 and for episodes with hip fractures vs. without hip fractures. By adding hip fracture status to our risk stratification approach, we believe we can capture a significant amount of patient-driven episode expenditure variation (page 73340).* While a quality measure in itself does not consider costs of care directly, underlying differences in patient populations that are not adequately identified in the design of a quality measure may misrepresent the quality of care delivered by providers that care for a higher proportion of higher cost emergent lower extremity surgery patients that are clinically different from those receiving elective procedures. **AHCA recommends** that the proposed reference category primary diagnosis group risk adjustment variable *"Hip and knee replacement"* be evaluated to determine whether it should be split into separate emergent versus elective diagnosis groups.	
	Interaction of admission mobility score and primary diagnosis group	**AHCA supports** the *"Interaction of admission mobility score and primary diagnosis group"* risk adjustment variable for this proposed measure.	
	Prior Surgery: Major surgery in the past 100 days	**AHCA supports** the *"Prior Surgery: Major surgery in the past 100 days"* risk adjustment variable for this proposed measure.	
	Prior Functioning: Indoor Mobility (ambulation)	**AHCA supports** the *"Prior Functioning: indoor ambulation"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Functioning: Stairs	**AHCA supports** the *"Prior Functioning: Stairs"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As	

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		this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Functioning: Functional Cognition	**AHCA supports** the *"Prior Functioning: Functional Cognition"* risk adjustment variable for this proposed measure. Prior function has been demonstrated in numerous research studies to be predictive of PAC functional outcomes and would be a significant improvement to the SNF MDS and to the usefulness of this proposed measure. As this Section GG 0100 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Walker	**AHCA supports** the *"Prior Device Use: Walker use"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Wheelchair/scooter	**AHCA supports** the *"Prior Device Use: Wheelchair/scooter"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Mechanical lift	**AHCA supports** the *"Prior Device Use: Mechanical lift"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Prior Device Use: Orthotics/prosthetics	**AHCA supports** the *"Prior Device Use: Orthotics/prosthetics"* risk adjustment variable for this proposed measure. As this Section GG 0110 item is already being collected by LTCH and IRF providers, the addition to SNF would further align the PAC function outcomes measures.	
	Communication Impairment:	**AHCA supports** the *"Communication Impairment"* risk adjustment variable for this proposed measure.	
	Cognitive abilities: Brief Interview for Mental Status (BIMS) score:	**AHCA supports** the *"Cognitive abilities: Brief Interview for Mental Status (BIMS) score"* risk adjustment variable for this proposed measure. This information is currently available on the SNF MDS and has performed well as a risk-adjustor in an AHCA-developed NQF-endorsed "#2612 CARE: Improvement in Mobility" quality measure.	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
		However, we believe that other cognition factors that are not captured by BIMS can also play an important role in predicting function and should be considered for future iterations of this measure. Specifically, under a separate CMS project, the RAND corporation is conducting a project titled *"Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data"* which includes a requirement to develop cross-setting patient assessment items related to the domain of cognition. In a recent data specifications document shared for public comment, the contractors presented the following items for consideration: 1) BIMS, 2) Expression of ideas and wants (addressed in item above), 3) Ability to understand others: Understanding verbal content, 4) Confusion assessment method (CAM), 5) behavioral signs and symptoms, and 6) Patient health questionnaire (PHQ). **AHCA also believes** there is merit to consider additional cognitive domain assessments when they become available in the public domain.	
	Bladder incontinence	**AHCA supports** the *"Bladder incontinence"* risk adjustment variable for this proposed measure.	
	Bowel incontinence	**AHCA supports** the *"Bowel incontinence"* risk adjustment variable for this proposed measure.	
	Presence of stage 2 pressure ulcer at admission	**AHCA supports** the *"Presence of severe pressure ulcer at admission (Stage 2 pressure ulcer)"* risk adjustment variable for this proposed measure.	
	Presence of severe pressure ulcer at admission (Stage 3, Stage 4, or Unstageable pressure ulcer)	**AHCA supports** the *"Presence of severe pressure ulcer at admission (Stage 3, Stage 4 or Unstageable pressure ulcer)"* risk adjustment variable for this proposed measure.	
	Swallowing ability:	**AHCA supports** the *"Swallowing ability"* risk adjustment variable for this proposed measure. **However, we request the exploration** of the concept of using a qualifier or gateway process to assure capture and align with the new Rules of Participation in SNF to give evidence of assessment for PO status, such as: 1) Patient assessed for PO status and treatment recommended, 2) Patient assessed for PO status and no treatment recommended, and 3) Patient to be assessed for potential to return to PO status	

Date Posted	Text of Comments		Name Credentials, and Organization of Commenter
	Total parenteral nutrition treatment	**AHCA supports** the *"Total parenteral nutrition treatment"* risk adjustment variable for this proposed measure.	
	History of falls in the past year:	**AHCA supports** the *"History of falls in the past year"* risk adjustment variable for this proposed measure.	
	Comorbidities (hierarchical condition categories):	In general, this appears to be a reasonably comprehensive comorbidities list. **We would appreciate seeing** a complete mapping of ICD-10 codes to this list. **Additionally, AHCA would appreciate** a more detailed description of the source of the comorbidities codes that will be used for calculating the proposed measure as well as the proposed lookback period for including these comorbidities in the measure calculation. For example, will these items be derived from all Medicare claims for a period prior to admission, or from data submitted by the SNF on claims or the MDS?	
	2.4.6 Calculation Algorithm	**AHCA generally supports** the overall *"Calculation Algorithm"* described for this proposed measure. **However, we have three concerns** that we would need to see addressed before we could endorse this approach. **First, we would appreciate a further description of how missing items would be addressed** in the calculation algorithm. **Second, we do not believe that there is sufficient detail explaining how the calculation will address all of the "activity did not occur" data points.** Specifically, step 1 of the calculation algorithm only identifies how *"activity not attempted"* values would be handled. We believe that this refers to response *88 – Not attempted due to medical condition or safety concerns*. There is no explanation regarding how the other *two "activity did not occur"* response options *09 – Not applicable* or *07 – Resident refused* would be handled. **AHCA recommends** that this be clarified. **Third, based upon our own experience in developing an NQF-endorsed mobility measure using the same CARE items and definitions, we have concerns with recoding the "activity not attempted" code response "88" to a '1' as described in Step 1.** Our statistical analyses of a sample of CARE data demonstrated that recoding	

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		these items to a 1 can create a statistically significant difference in the discharge score calculations. Additionally, recent CMS training emphasizes that, despite the item response terminology for response "88," if something cannot be assessed", providers are to code it activity not attempted and that "clinical inferences" should not be made. **AHCA recommends** that analysis comparing the risk- adjustment measure calculation impacts of recoding versus excluding any or all of the three "activity did not occur" item responses, including the percentage of patient stays impacted, and that these results are shared with stakeholders for comment before advancing this proposed measure.	
	APPENDIX A: RELIABILITY AND VALIDITY TESTING		
	A.1 Overview of Reliability and Validity Testing	**We believe** that the description on page 35, first paragraph, last sentence is incomplete. **AHCA recommends** that long-term nursing placement be added as a discharge planning option into the sentence. For example – *"The functional status items on the CARE Item Set are daily activities that clinicians typically assess at the time of admission and/or at discharge to determine patients'/residents' needs, evaluate patient/resident progress, and prepare patients/residents and families for a transition to home, ~~or~~ to another setting, or to remain as a long-term nursing facility resident."*	
	A.3 Videotaped Standardized Patients Reliability Study	The weak video reliability of clinicians identified in the "other" category "mostly LPNs" (page 38, second paragraph second sentence) demonstrates that significant training will need to be targeted for such "other" clinicians if this measure is adopted for SNF. **AHCA recommends** that any data specifications submitted to CMS from this project include a strong recommendation for CMS to develop and disseminate extensive measure coding guidance, including at a minimum voluntary competency testing, to better assure that all individuals authorized to submit functional assessment items are proficient.	
11/4/16	As the largest provider of inpatient rehabilitation facility ("IRF") services in the nation, and in partnership with Encompass Home Health, the fourth largest Medicare home health ("HH") provider, we appreciate the opportunity to submit comments on your work for of the Centers for Medicare and Medicaid Services ("CMS") regarding the development of the SNF Functional Outcome Quality Measures. We operate three SNF units within the HealthSouth network and, by virtue of having implemented the IRF version of these SNF measures in HealthSouth IRFs over the course of the past year (with reporting beginning October 1, 2016), we have an interest in helping RTI International ("RTI") craft measures that prove helpful across the spectrum of post-acute care ("PAC") providers. We have several comments that will serve as constructive additions to the development of these measures. We hope that RTI and CMS		Andrew C. Baird HEALTHSOUTH Director, Government Relations

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	will analyze and consider these comments and how they could improve the framework for this suite of post-acute care functional outcome quality measures. **I. CLINICAL CONCERNS WITH THE CARE ITEM SET FOR USE IN MEASURING FUNCTION** These SNF functional outcome measures all rely on the 6-level functional scale developed as part of the Continuity Assessment Record and Evaluation ("CARE") Item Set. For providers of rehabilitation therapy, this scale contains several shortcomings that can affect patient care and safety in a SNF environment. We urge RTI and CMS to remain aware of these drawbacks with the functional scale utilized by these measures. **A. The "Independent" rating is overly-broad** The design of the CARE Item Set's definitions demonstrates how patient safety can be jeopardized when they are applied. The highest score on the 6-level functional scale utilized by these SNF measures is "Independent" (Level 6), and it includes both patients who are completely independent as well as patients who require equipment (i.e., cane, walker) and/or additional time to complete a task safely. This grouping (patients who are completely independent along with patients who need device assistance) is a concerning oversimplification of functional measurement. To use walking as an example, academic research shows that patients who need mobility devices, like a cane or a walker, are at demonstrably higher risk of falling than patients who can walk without such devices.[1] The difference between these levels of function (that is, between whether a patient can walk without any assistance, or requires the use of a device) is an important determinate in a clinician's ability to appropriately assess a patient's risk of falling. Furthermore, there are significant functional and psychological outcome distinctions between walking with or without a mobility device, and the effects of mental and emotional hurdles a patient must endure before accepting to use a cane or walker following an injury.[2] We believe measures designed to assess function must be able to account for these important evidence-based differences so that an accurate assessment of overall progress in a care setting can be made. By not accounting for these critical distinctions, these measures are unable to capture clinically significant components of functional recovery. For example, home health services are often prescribed to patients being discharged from an SNF for the sole purpose of helping reduce dependency on a device while walking. However, if the patient's functional rating from the 6-level scale does not distinguish between walking independently and walking with the use of a device, then home health or other necessary services may not be ordered because the tool does not provide clinicians and caregivers with a precise enough assessment of the patient's actual ambulation capabilities. If home health were ultimately prescribed and helped the patient meet his/her goal of no longer needing a device to walk, this functional scale would nevertheless fail to capture that significant step in functional progress made between the SNF discharge (when the patient could only walk with a device) and the end of the home health episode (when the patient no longer needed a device).	

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	B. The "Supervision" functional rating is not sufficiently precise Similarly, the measures' middle score of "Supervision or Touching Assistance" (Level 4) makes no distinction between requiring touching assistance or supervision assistance to perform a specific task safely. The actual functional difference between a patient who needs active touching assistance and a patient who only requires supervision is extremely meaningful. If, upon discharge to home, a family support in the patient's home presumes the patient only needs supervision while completing a task (such as toileting), but the patient actually requires consistent touching assistance, the risk that an otherwise preventable fall or other injury occurs increases because the patient's functional rating on these measures is not sufficiently precise to distinguish between these materially different states of functional capacity. This shortcoming could, in turn, result in the patient's subsequent re-hospitalization if a fall with injury occurs as a result of a misunderstanding of the level of assistance needed from a family member or caregiver. **C. The "Substantial/Maximal Assistance" functional rating is not sufficiently precise** Similarly, the scale's lower score of "Substantial/Maximal Assistance" (Level 2) in the CARE Item Set scale includes both patients that need a helper to perform between 0-25% of an activity for them, as well as patients that need a helper to perform between 25-50% of the activity. Truncating such a broad spectrum of functional capacity (from 0% to 50%), particularly those levels that cover low function, into a single functional rating fails to precisely reflect actual outcome or accurately communicate the level of assistance that a patient requires to complete a task safely. For example, if a patient is rated in the Level 2 category, a clinician is only aware that the patient needs less than 50% of support, and may incorrectly presume that he/she needs less support than necessary (e.g., clinician may presume patient needs 10% assistance when patient actually needs 50% assistance). [1]*See* J. GERIATRIC PHYS. THERAPY, 2015;00:1-6; ONTARIO HEALTH TECHNOLOGY ASSESSMENT SERIES 2008; Vol. 8, No. [2]*See* Gitlin, Laura N. "Why Older People Accept or Reject Assistive Technology." *American Society on Aging* 14.1 (1995). Rpt in http://www.homemods.org/resources/pages/accept.shtml; Resnik, Linda et al. "Perspectives on Use of Mobility Aids in a Diverse Population of Seniors: Implications for Intervention." *Disability and health journal* 2.2 (2009): 77–85. In addition to the risk of a caregiver under- or over-estimating the amount of assistance a patient actually needs, this overly-broad rating "Substantial/Maximal Assistance" presents the problem where a caregiver is unable to detect deterioration in function that could be the first sign of a more serious clinical complication. For example, imagine a clinician comes on duty to take care of a patient for the first time. If a caregiver notes the patient can only perform about 10% of an activity independently, that might not raise any red flags if the patient had previously been rated Level 2 on the CARE scale used by these measures. However, an actual decline in function from 40% to 10% could prove to be a strong indicator for medical assessment and intervention.	

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	D. "Usual performance" v. "minimal performance" Furthermore, the CARE functional scale, by measuring patients' "usual performance" in assigned functional tasks, does not adequately assess the real burden of care of a patient and excludes critical information that is needed to determine whether a patient can return home, or what support services will be required. The need for family-provided care or other services after discharge for a patient with functional impairments should not defined by their "usual performance," but instead by their lowest or their "most dependent performance." Caregivers who are only prepared for a patient's "usual performance" may not provide enough assistance to a patient should he/she temporarily be reduced to "most dependent performance" levels. If a measurement tool does not equip clinicians, patients, and families to plan for how to meet this realistic "burden of care," discharge plans would be less effective and the risk of hospital readmissions or alternative institutionalization would rise. **E. Concerns Regarding the Inconsistency of Measure 2634 Calculations According to Patient Ability** The calculation of measure 2634 creates inconsistencies in how it treats patients, with some patients being scored differently than others. This means that some patients may not have key components of their functional capacity accounted for by the measure calculation, thus creating an inconsistency (and potential inaccuracy) in the resultant data that may prove difficult to account for by risk-adjustment alone. For example, listed below are the 15 mobility items that comprise measure 2634 (according to the measure specifications as endorsed by NQF). These are the items that are used to calculate the numerator of the mobility measure for all patients. Missing from this list are any wheelchair mobility items. Although these wheelchair mobility items are scored on the MDS by the SNF clinician during the functional assessment (GG 0170R "Wheel 50 feet with two turns" and GG 017S "Wheel 150 feet"), these wheelchair items are *not* included in the actual mobility measure calculation.[3] Not only does this mean that there is a discrepancy between how a wheelchair patient is assessed and how the measure is calculated, but it means that the data produced for wheelchair patients will not depict the change from a wheelchair mobility level on admission. 1. GG 0170A. Roll left and right 2. GG 0170B. Sit to lying 3. GG 0170C. Lying to sitting on side of bed 4. GG 0170D. Sit to stand 5. GG 0170E. Chair/bed-to-chair transfer 6. GG 0170F. Toilet transfer 7. GG 0170G. Car transfer 8. GG 0170I. Walk 10 feet 9. GG 0170J. Walk 50 feet with 2 turns 10. GG 0170K. Walk 150 feet 11. GG 0170L. Walking 10 feet on uneven surfaces	

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	12. GG 0170M. 1 step 13. GG 0170N. 4 steps 14. GG 0170O. 12 steps 15. GG 0170P. Pick up object Furthermore, if a patient cannot walk at admission, *even if a walking goal is clinically indicated*, the above highlighted items (GG 0170I through GG 0170P) are not assessed (the clinician is asked to skip items I through P). We have illustrated these discrepancies via example patient scenarios in the below table. These particular scenarios occur in Patients B and C in the table. This exclusion of wheelchair items from the measure calculations means the patient lacks 8 of the 15 items used to calculate the mobility measure at admission and/or discharge. This design aspect causes the measure to be inconsistent across patients who have different functional abilities, since some patients will have all 15 items counted toward their functional change and others will only have 8 items counted toward their functional measure. It is unclear how patients who are unable to walk or who are wheelchair dependent at admission (and therefore have a null value for those 8 unscored items) will earn a functional change for items scorable at discharge. This scenario is illustrated by Patient B. The table below helps to further illustrate this consistency problem. The maximum functional change patients can achieve varies by their functional ability, a problem that is not addressed or resolved in the measure specifications or any of the supporting literature. [3]*See* SNF MDS Version 3.0, Corrected Version 1.14.0, Item GG, *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/NursingHomeQualityInits/Downloads/MDS-30-SECTIONS-A-AND-GG-DOCUMENT.pdf.	

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter

Patient A – walking at admission and discharge		Patient B – unable to walk at admission, but walking at discharge		Patient C – Unable to walk at admission and discharge	
Elements Scored at Admission	**Elements Scored at Discharge**	**Elements Scored at Admission**	**Elements Scored at Discharge**	**Elements Scored at Admission**	**Elements Scored at Discharge**
A	A	A	A	A	A
B	B	B	B	B	B
C	C	C	C	C	C
D	D	D	D	D	D
E	E	E	E	E	E
F	F	F	F	F	F
G	G	G	G	G	G
I	I	not completed	I	not completed	not completed
J	J	not completed	J	not completed	not completed
K	K	not completed	K	not completed	not completed
L	L	not completed	L	not completed	not completed
M	M	not completed	M	not completed	not completed
N	N	not completed	N	not completed	not completed
O	O	not completed	O	not completed	not completed
P	P	not completed	P	not completed	not completed
15 total items	**15 total items**	**7 total items**	**15 total items**	**7 total items**	**7 total items**
Score range: 15-90	Score range: 15-90	Score range: 7-42	Score range: 15-90	Score range: 7-42	Score range: 7-42
Maximum change in functional mobility patient could achieve: **75**		Maximum change in functional mobility patient could achieve: **Unclear, since items I-P have no score at admission**		Maximum change in functional mobility patient could achieve: **35**	

*Wheelchair items R and S are not listed since they are not included in measure 2634 numerator calculations

Since October 1, 2016, similar CARE functional measures have been collected at Inpatient Rehabilitation Hospitals (IRFs). Based on a review of approximately 16,000 Medicare FFS patients discharged from IRFs during October, 2016, over 16% of patients are not walking at admission (represented as Patient B in the chart above) and thus have items GG0170 I-J skipped at the admission assessment.[4] Of those, 9% are not walking at admission or at discharge (represented as Patient C in the chart above), and have items GG0170 I-J skipped at both admission and discharge.

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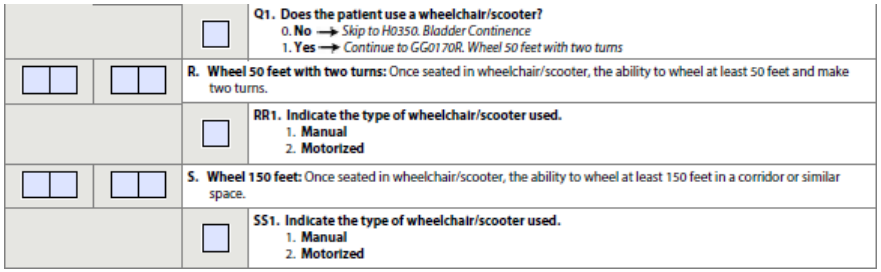
	Additionally, 60-70% of all of these IRF cases have the wheelchair/scooter mobility (GG 0170R "Wheel 50 feet with two turns" and GG 017S "Wheel 150 feet") assessed. However, because these items, depicted below, are excluded from the measure specifications, they are not included in the quality measure used to assess functional improvement.	



☐	**Q1. Does the patient use a wheelchair/scooter?** 0. **No** → *Skip to H0350. Bladder Continence* 1. **Yes** → *Continue to GG0170R. Wheel 50 feet with two turns*
☐☐ ☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
☐	**RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐ ☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
☐	**SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

[4]Data collected by Uniform Data Systems for Medical Rehabilitation (UDSMR)

Additionally, any progress gained in the functional items related to wheelchair/scooter mobility (GG 0170R "Wheel 50 feet with two turns" and GG 017S "Wheel 150 feet") will not be counted in the mobility score, since these items are not included in the numerator calculations (according to the measure specifications). An important part of rehabilitation therapy provided in skilled nursing facilities is to train patients who may never walk again, perhaps due to a spinal cord injury or severe stroke, on how to utilize a wheelchair or scooter. Many patients receive their first wheeler or scooter when they arrive at a SNF, and rehabilitation therapists help them become functionally mobile with their new device. Measure 2634 also fails to assess a patient's ability to lock and unlock their wheelchair and/or remove or move leg rests - all important factors in a patient's ability to become independently mobile with their wheelchair/scooter device. For providers who often treat wheelchair- or scooter-bound patients, it is a serious concern that clinically significant functional improvement achieved by such patients may not be measured.
To better account for the patient who is unable to walk and/or who is wheelchair dependent at admission and discharge (regardless if they use a wheelchair/scooter) the functional measure should be modified to either:

- Exclude the walking items (that are currently skipped) for patients who do not walk and replace with the commonly used wheelchair items GG0170 R-S, or
- Create a specific risk-adjustment factor for patients who do not walk either at admission or discharge.

II. TRAINING AND GUIDANCE FOR SNF MEASURES MUST BE BETTER

During CMS' roll-out of the IRF version of these functional outcome measures, the Agency provided training and guidance to IRF providers that often created more questions than answers. Even after the IRF measures' initial October 1st start date, multiple questions regarding the collection of functional data remain. We urge RTI and CMS to review

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	and improve the provider training offered to SNFs in an effort to reduce questions and uncertainty well before the eventual reporting start date. **III.** SNF VERSIONS OF FUNCTIONAL OUTCOME MEASURES SHOULD BE CONSISTENT WITH THE IRF AND OTHER PAC PROVIDER VERSIONS Standardization of functional outcome data is consistent theme in the continued implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 ("IMPACT Act"). Although these four particular outcome measures are not specifically required under the IMPACT Act's statutory standardization framework, CMS states in the original promulgation of these measures that the data elements used to inform these measures are part of a larger set of functional status data items that have been or will be added to the various PAC assessment instruments (e.g., SNF MDS, IRF PAI, etc.) "for the purpose of providing standardized data elements" under the IMPACT Act's domain of functional status.[5] Without reciting *in toto* the inherent value of developing truly standardized (that is, identical) measures for use across the four major PAC settings, CMS' statement regarding the utilization of these particular measures to provide standardized data under the IMPACT Act indicates the Agency's intent to use these on a cross-setting basis. Accordingly, any design differences between the original versions of these measures, as developed for the IRF setting, and these currently proposed SNF versions, are troublesome and should be rectified early on in the measure development process. These differences are detailed as follows. **A. Measure Exclusions Should Be Uniform for All PAC Providers** The measure exclusions used in these SNF measures should be in lock-step with the original IRF versions. However, the Draft Measure Specifications document lists two glaring discrepancies between the exclusions employed in these SNF measures and those utilized in the versions already finalized and implemented within IRFs. 1. *"Residents who are not Medicare fee-for-service beneficiaries"* The IRF version of these measures includes Medicare Advantage ("MA") beneficiaries in addition to traditional fee-for-service, but the SNF versions exclude MA altogether, focusing only on fee-for-service. MA is now a now large and continually growing portion of the Medicare population and thus covers a significant number of SNF patients. By categorically excluding Medicare managed care, these measures would not only ignore this important patient population, but also create a concerning discrepancy with the way these measures assess the IRF population. 2. *"Residents who do not have an expectation of functional improvement"* The draft measure specifications exclude any SNF patients who do not have an expectation of functional improvement, meaning only patients with functional improvement expectations will be covered by these measures.	

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	[5]FY 2016 IRF Prospective Payment System Proposed Rule, 80 Fed. Reg. 23332, 23391 (Apr. 27, 2015) (discussing why CMS is proposing these measures as part of the IMPACT Act's framework despite not being required to do so under the same legislation). First, this exclusion is only in the SNF version and not used in the IRF version of these measures. Measures that CMS intends to be standardized across settings should be aligned as much as possible. By excluding any patient who does not have an expectation of functional improvement within a SNF, this measure would only examine those SNF patients who may functionally improve while only in a SNF-level of care (a level of care that is lower in acuity than that provided in IRFs), that is, those who are likely the most healthy and capable of all SNF patients. Second, this exclusion stands to exclude a large portion of SNF residents from functional outcome measurement, meaning their *n* sizes could be relatively small and therefore unrepresentative of a SNF's overall quality in terms of functional capacity maintenance. Furthermore, by excluding patients without an expectation of functional improvement, this exclusion *apriori* exempts SNF patients for whom functional maintenance (that is, who must work to remain at a given functional level) is a clinically and personally important goal, as well those patients for whom functional improvement may occur despite only having expectation for functional maintenance. Excluding these two classes of patients is inappropriate given that, in both cases, either their functional maintenance or unexpected functional improvement may ultimately represent a real and important clinical goal. Third, there is currently no objective method of determining which patients have expectations for functional improvement, thus begging the question as to who will make this critical determination and how it will be made. Will it simply be based on MS-DRG? Or is it a decision made by the patient? The description of the exclusion, "a patient who has expectations…", appears to read as though two different patients with the same condition may each "choose" whether they expect to functionally improve. On the other hand, is it a clinician who is to decide? And if so, is it a therapist or nurse? Or a SNF administrator? Fourth, without an objective and reliable way to determine which patients have expectations of functional improvement, this exclusion opens the measure up to gaming, particularly if the determination is housed exclusively within the SNF staff. Certainly many SNFs operate with clinical integrity, but bad actor SNF operators may aim to improve their performance on these measures by unilaterally excluding certain of their patients who are predisposed to demonstrating very little functional improvement during their stay, but who nevertheless harbor legitimate expectations of functional improvement. These patients may be marked as having "no expectation" of functional improvement (when in fact they do), and then would be inappropriately removed from being assessed as part of these measures. Fifth, and finally, regardless of how the decision is made regarding expectation of improvement, we do not believe that an expectation (or lack thereof) or a particular clinical outcome (i.e., positive functional improvement) should serve as	

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	the determinant in how a measure, which is designed to capture the prevalence and/or success of that very outcome, is crafted. This is not the case in other quality measures. For example, another IMPACT Act measure, Discharge to Community (both IRF and SNF versions), which measures the frequency of PAC patients who are discharged to a community setting from a provider, does not exclude those patients who have no expectation of being discharged to the community merely on account that expectation. However, the draft versions of these SNF functional measures do just the opposite – as measures of functional progress, they would exclude patients who do not have an expectation of positive functional gains – and we believe this is an inappropriate element of their design because it eliminates patients whose functional improvement success (of lack thereof) is an indicator of how well a provider performs in this particular area of care. Accordingly, we believe this exclusion should be removed from the SNF version of these measures, both for reasons of parity with the existing IRF versions, but also for the legitimate questions it raises as to which patients would and would not be excluded in actual practice, and the questionable basis on which they would be excluded. **B. Risk-Adjustment Methodology** The risk-adjustment factors for the SNF measures are nearly identical to the existing IRF versions. However, whereas the fourth risk-adjustment factor, "primary rehabilitation diagnosis," is determined in IRFs by a specific "Impairment Group Code" ("IGC") via IRF PAI Item 21, the SNF MDS does not include any similar code-based diagnosis item which could be used to indicate a patient's primary SNF rehabilitation diagnosis. Accordingly, it is unclear under the current draft specifications what information would serve as the basis for this risk-adjustment factor in the SNF setting. Without a direct analogue for IRF IGCs on the SNF MDS, we are uncertain how this factor would impact the output of these measures. In these draft SNF functional measures, RTI has also included an additional sub-group within the "primary rehabilitation diagnosis" risk-adjustment factor called "Conditions requiring invasive mechanical ventilation." This sub-group is not included in the IRF version of the measures. For purposes of data standardization, we think that risk-adjustment should be identical between PAC settings. **IV. CONCLUSION** Thank you for your attention to these comments. We hope our views and insights will prove constructive in the development of the SNF functional outcome measures, especially at this stage in the development process. Should you wish to discuss any content contained in this letter, please contact us at the information below.	
11/4/16	We support the development of meaningful quality measures, and appreciate the opportunity to comment on the functional outcome quality measures for skilled nursing facilities (SNF). We encourage the development of reportable metrics for SNFs to compare quality and value of their services.	Kate Romanow Senior Policy Manager, JD Blue Cross and Blue Shield Association

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	Our comments are as follows: • Denominator Exclusions. We are concerned that the measures have an excessive amount of exclusions. If there are too many exclusions, it could be easy to manipulate, leading to a denominator that is too small to be statistically meaningful. For example, we are concerned about excluding patients discharged to hospice, as these patients also deserve high quality care. Some patients may receive hospice care earlier in their course, rather than weeks before dying, and SNFs should be accountable for delivering quality services to them. Putting this class of patient in the exclusions section perpetuates inequality in care delivery as well as an outdated concept of hospice care. • Self-Care Measures. We support the self-care measures (2.1 and 2.3), and suggest that other self-care metrics be included, such as the ability to self-medicate, or ability to understand their medication regimen. These factors affect the ultimate home-care plan including whether family caregivers or home care team members need to have training and assistance in assuring the patient's medication regimen is followed. • Potential Future Measures. We encourage development of more robust metrics going forward. For example, attention could be paid to functional status, ideally comparing status prior to hospitalization (usually the precursor to SNF treatment), to status on admission to SNF, to status on discharge, to status at a future point in time (maybe 90 days). For instance, if the individual was walking 2 miles a day at baseline, can we measure how long it takes her to return to that level of functionality? Or if a patient was working at baseline, how long does it take him to return to that status post-discharge? There are precedents for functional status metrics (such as for physical therapy) that could be modified for this population. BCBSA welcomes the opportunity to work with you on developing quality measures. If you have any questions or need additional information, please contact Vanessa Sammy at vanessa.sammy@bcbsa.com	
11/4/16	On behalf of Uniform Data System for Medical Rehabilitation (UDSMR) and the nearly one thousand postacute care (PAC) facilities (IRFs, SNFs, and LTCHs) we provide services to, we are pleased to present our comments related to the Development of Functional Outcome Quality Measures for Skilled Nursing Facilities (SNFs). We appreciate the continuing efforts of RTI International and CMS to allow stakeholders to comment on items and tools designed to help measure quality in healthcare, with an emphasis on developing standardized and interoperable measures within PAC settings. UDSMR strongly believes that CMS and its contractors should focus on identifying measures that • have a long history or extensive evidence of being reliable and valid; • are in use or have been used by providers in all PAC venues; • are predictors of quality, cost, and payment; and • have been endorsed, approved, and/or found to be “best in class” by industry stakeholders. UDSMR has the following overall comments and concerns related to the measures proposed for the Development of Functional Outcome Quality Measures for Skilled Nursing Facilities (SNFs):	Troy Hillman Uniform Data System for Medical Rehabilitation

Date Posted	Text of Comments	Name Credentials, and Organization of Commenter
	1. The proposed measures are not endorsed by the National Quality Forum (NQF) for SNFs, while NQF has endorsed two other sets of functionality quality measures for SNF populations. As stated above, UDSMR believes that RTI International and CMS should be proposing to implement quality measures that have been endorsed, approved, and/or found to be "best in class" by stakeholders such as NQF. 2. To support the IMPACT Act, RTI International and CMS continue to propose quality measures that are not standardized and cannot be considered as crosscutting due to setting-specific inclusion/exclusion criteria and risk- adjustment factors. a. The proposal to exclude SNF residents who do not have an expectation of functional improvement is inconsistent with the IRF measures. Risk adjustments for these measures, which include the effects of certain impairments, comorbid conditions, and prior functioning level, should account for these circumstances without a requirement for a specific exclusion. b. The exclusion of Medicare Advantage (Part C) cases differs from IRF requirements and does not provide the ability to measure quality within a population of cases that are growing. 3. The proposed mobility measures have significant flaws. a. Patients who utilize a wheelchair and do not walk during the PAC stay will not be measured on eight of the fifteen items used in the mobility measures, significantly affecting their ability to report functional status at discharge or changes in functional status resulting from the PAC stay. b. The mobility measures and their resulting values are heavily influenced by the use of multiple items to report on a common construct, inflating the patient's perceived functional status or change in functional status. Ambulation is measured and reported for four separate items, while the ability to navigate stairs is measured and reported for three separate items. c. Preliminary results from the UDSMR® IRF database indicate that a number of the items used in the mobility measures are unable to be adequately assessed at admission, with 50% or more of the Medicare patient data indicating that the item was not attempted due to medical condition or safety concerns, that the item was not applicable to the patient, or that the patient refused to perform the activity. 4. UDSMR and its subscribers believe there are multiple issues related to the sensitivity of the rating scale used for these items, such that resulting measures do not accurately represent the quality improvements made during the patient's PAC stay. 5. The costs to the Medicare program attributable to implementing additional assessment items for measures that have not been found to be predictive of quality, cost, or payment need to be considered prior to implementation. The remainder of this letter provides additional detail related to these concerns.	

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Although NQF has reviewed and provided conditional endorsement for all the proposed measures for the IRF population, it has not reviewed them specifically for the SNF population. This means that industry stakeholders have not been able to thoroughly evaluate whether the proposed measures are reliable, valid, and/or appropriate for measuring the quality of functional status within SNFs.
Similar and competing functional status measures from UDSMR and AHCA have been through the NQF stakeholder review process and have been endorsed by NQF for use in SNFs. RTI International and CMS have neither proposed nor recognized the following measures as being available for use in the SNF setting even though they have received the appropriate level of stakeholder evaluation.
<table>
<tr><th>NQF#</th><th>Measure Name</th><th>Steward</th></tr>
<tr><td>2774</td><td>Functional Change: Change in Mobility Score for Skilled Nursing Facilities</td><td>Uniform Data System for Medical Rehabilitation</td></tr>
<tr><td>2775</td><td>Functional Change: Change in Motor Score for Skilled Nursing Facilities</td><td>Uniform Data System for Medical Rehabilitation</td></tr>
<tr><td>2769</td><td>Functional Change: Change in Self-Care Score for Skilled Nursing Facilities</td><td>Uniform Data System for Medical Rehabilitation</td></tr>
<tr><td>2612</td><td>CARE: Improvement in Mobility</td><td>American Health Care Association</td></tr>
<tr><td>2613</td><td>CARE: Improvement in Self-Care</td><td>American Health Care Association</td></tr>
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Before RTI International and CMS implement the proposed measures for SNFs, we believe that an independent stakeholder committee should evaluate the NQF-endorsed SNF measures in this table and that only those measures found to be “best in class” should be implemented.
2. To support the IMPACT Act, RTI International and CMS continue to propose quality measures that are not standardized and cannot be considered as crosscutting due to setting-specific inclusion/exclusion criteria and risk-adjustment factors.
As we have seen throughout CMS’s implementation of the IMPACT Act, quality measurement is being administered differently across the various PAC settings. If the intent of the IMPACT Act was to facilitate comparisons across all PAC providers by creating standardized elements for quality measures, we continue to be concerned that CMS and
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	its contractors are creating quality measures designed specifically for use within one of the various PAC settings. Although the data elements within the measures may be identical or similar, the calculations, risk-adjustments, and inclusion/exclusion criteria that are unique to each setting make it impossible to produce valid comparisons across all PAC settings. **a. The proposal to exclude SNF residents who do not have an expectation of functional improvement is inconsistent with the IRF measures. Risk adjustments for these measures, which include the effects of certain impairments, comorbid conditions, and prior functioning level, should account for these circumstances without a requirement for a specific exclusion.** Although there are patients within each PAC setting who may have limited to no potential for functional improvement, the proposal to add exclusions for these patients comes with several issues. First, this would cause the quality measures to differ from those that are endorsed by NQF and implemented for IRFs and therefore would signify that these measures have not been reviewed and/or approved by industry stakeholders. NQF would need to review any changes to an NQF measure's specifications to determine whether the changes would affect the endorsement of the measure. Second, RTI International and CMS fail to explain in detail how this exclusion will be determined, who will be determining whether a patient has the potential for functional improvement, and when this determination will be made. Without providing these details, it is impossible to determine what, if any, effect this may have on the quality measures. Third, neither RTI International nor CMS has provided any testing or information to determine whether this exclusion is necessary or whether the existing risk adjustments included in these measures may account for these circumstances. These measures already adjust for the effects of impairments, comorbid conditions, and prior functioning level among many other risk-adjustment factors. Can RTI International or CMS show that the proposed exclusion is absolutely necessary, given these various adjustments? Finally, consideration must be given as to whether this exclusion criterion may affect access to care within other PAC settings. As quality metrics move toward public reporting, the ability for SNFs to exclude certain patients while other providers are held responsible for similar patients may cause circumstances that direct patients toward levels of care that may not be best for them, their families, or their conditions. Additionally, because the criteria for this determination is not well defined, who can say whether a patient who may have the potential for limited improvement will be directed toward a SNF for exclusion in quality measurement so as not to risk harm to an IRF quality metric?	

	b. The exclusion of Medicare Advantage (Part C) cases differs from IRF requirements and does not provide the ability to measure quality within a population of cases that are growing. Although UDSMR understands that completion of the MDS assessments is not required for Medicare Advantage (Part C) patients, IRFs are required to submit and measure data on these cases for the purposes of compliance and quality reporting. Suggesting that SNFs are not responsible for the care provided to these patients once again produces the inability to compare quality in a standardized manner across PAC providers. Additionally, MedPAC, in its June 2016 Data Book: Health Care Spending and the Medicare Program, noted that 31% of all Medicare beneficiaries or roughly 17.2 million beneficiaries are enrolled in Medicare Advantage plans. This population increased by over ten million beneficiaries over the last ten years and shows a consistent growth pattern of roughly one million additional beneficiaries per year enrolling in Medicare Advantage plans. Excluding this population from SNF quality measurement not only differs from the IRF measure, but also stands to exclude nearly a third or more of all Medicare beneficiaries from standardized data collection and quality reporting. **3. The proposed mobility measures have significant flaws.** **a. Patients who utilize a wheelchair and do not walk during the PAC stay will not be measured on eight of the fifteen items used in the mobility measures, significantly affecting their ability to report functional status at discharge or changes in functional status resulting from the PAC stay.** After discharge from an acute care stay, a number of Medicare patients are unable to walk upon admission to a PAC provider. Some patients may also be discharged with a condition for which wheelchair use may be required for a prolonged period of time, or even indefinitely. Accordingly, use of a wheelchair may be necessary for mobility purposes. However, the mobility measure specifications and the associated data collection do not account for these circumstances and may affect the quality measure values for these patients and the providers who care for them. To detail this issue, during the admission and discharge assessments, providers indicate whether the patient walks or not. If the patient is walking, providers then proceed to assess eight items that measure the patient's ability to walk 10 feet, walk 50 feet with two turns, walk 150 feet, walk 10 feet on an uneven or sloping surface, proceed up and down one step (curb), proceed up and down four steps, proceed up and down twelve steps, and pick up an object from a standing position. If the patient does not walk, these items are skipped, and their values are left blank. All eight items described above are a part of the mobility quality measure, which has a total of fifteen items. For patients who are unable to walk, this means that over half of the information that is used to measure their functional mobility will not be collected, and their resulting functional quality measures will be significantly lower than other patients who walk during their PAC stays.	

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	Preliminary data from the UDSMR® IRF database suggests that roughly 16% of all Medicare patients are not walking at admission, while roughly 9% do not walk at discharge. For these patients, their mobility functional status will be left blank for the eight items noted above. To account for these circumstances, UDSMR recommends that RTI International and CMS consider the following potential adjustments to the SNF and IRF measures: 1. Remove items from the mobility measure that cannot be assessed for all patients. 2. Add the wheelchair mobility items for those who do not walk (Wheel 50 feet with two turns and Wheel 150 feet), keep the common walking items for those who do walk (Walk 50 feet with two turns and Walk 150 feet), and remove all other items that are unique to patients who walk. 3. Provide evidence that existing risk-adjustment factors will provide consistency between the quality measures of patients who do not walk and those of patients who do. 4. Create a risk adjustment specific to patients who do not walk during their PAC stays. 5. Utilize the UDSMR® mobility measure that assesses locomotion regardless of whether a patient walks or uses a wheelchair. **b. The mobility measures and their resulting values are heavily influenced by the use of multiple items to report on a common construct, inflating the patient's perceived functional status or change in functional status. Ambulation is measured and reported for four separate items, while the ability to navigate stairs is measured and reported for three separate items.** Another issue with the proposed mobility measures is that the patient's ability to ambulate and to navigate stairs may overly influence the measurement of the patient's performance due to the sheer number of items dedicated to these functional abilities. A provider who dedicates a significant amount of resources just to these two functions may result in positive facility performance without producing a significant, durable, reliable, and/or valid result for the patient on the other mobility functions. For ambulation, patients are to be assessed on four items: 1. Walk 10 feet 2. Walk 50 feet with two turns 3. Walk 150 feet 4. Walk 10 feet on uneven surfaces These four items constitute over 25% of the mobility measure values, and with a scale of 1–6 for measuring these items, the variability of patient performance is significant. However, all these items assess the same thing: a patient's ability to ambulate. If a patient is capable of walking 150 feet independently, the probability that the patient is capable of walking 10 feet is highly likely. Conversely, if a patient cannot walk 10 feet, it is highly unlikely the patient can walk 150 feet. In these	

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circumstances, does it make sense to measure both distances and then record the patient's performance on both? Would one item with a common distance be sufficient for evaluating ambulation?

Similarly, the ability to navigate stairs is assessed using three items:

1. 1 step (curb)
2. 4 steps
3. 12 steps

In addition to the issues noted above with ambulation—namely, that performance at both the high and low levels call into question the need to use more than one item to assess this ability—these items present another issue for patients who do not live in a location with stairs, as well as those who never use stairs. For these patients, the recommendation is that the items be recorded as not applicable; however, doing so would prevent these patients from being viewed as having functional improvement. Again, we wonder whether all three items are necessary for assessing the ability to navigate stairs, or whether one item would be sufficient to assess this ability.

c. Preliminary results from the UDSMR® IRF database indicate that a number of the items used in the mobility measures are unable to be adequately assessed at admission, with 50% or more of the Medicare patient data indicating that the item was not attempted due to medical condition or safety concerns, that the item was not applicable to the patient, or that the patient refused to perform the activity.

After a month of data collection, the UDSMR® IRF database contains roughly 16,000 Medicare Fee-for-Service records discharged in October 2016 who have assessed the new section GG items used in these measures. In evaluating the mobility measures, we noticed that more than half of the patients did not attempt the activity for seven of the fifteen items, whether because the patient refused, the activity wasn't applicable, or the activity was not attempted due to medical condition or safety concerns. The following table lists the items and percentage of cases in which the activity was not attempted at admission.

Item	Percentage of Cases Not Attempted at Admission
Car Transfer	77%
Walk 150 Feet	70%
Walk 10 Feet on Uneven Surface	74%
1 Step (Curb)	60%
4 Steps	63%
12 Steps	86%
Picking Up Object	66%

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	Because more than half of all Medicare patients are not attempting these activities at admission, we question these items' utility in measuring mobility. We also question whether mobility may be able to be measured by a smaller set of items that are capable of being assessed on a more significant percentage of patients. We also question whether measuring the amount of functional change from admission to discharge is appropriate in these instances, since the admission value indicates that the activity wasn't attempted to determine an appropriate functional level for these patients. UDSMR recommends that RTI International and CMS provide evidence as to whether these items are appropriate for quality measurement and whether they add value to the measurement of quality outcomes. **4. UDSMR and its subscribers believe there are multiple issues related to the sensitivity of the rating scale used for these items, such that resulting measures do not accurately represent the quality improvements made during the patient's PAC stay.** RTI International and CMS have chosen a scale of 1–6 for the items used in the functional measures. The levels for this scale are defined as follows: **6, Independent:** Resident completes the activity by himself/herself with no assistance from a helper. **5, Setup or clean-up assistance:** Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity. **4, Supervision or touching assistance:** Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. **3, Partial/moderate assistance:** Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports resident's trunk or limbs, but provides less than half the effort. **2, Substantial/maximal assistance:** Helper does MORE THAN HALF the effort. Helper lifts or holds resident's trunk or limbs and provides more than half the effort. **1, Dependent:** Helper does ALL of the effort. Resident does none of the effort to complete the task. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.	

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	IRFs have struggled with this new scale because they have been accustomed to using the following seven-level scale: **No Helper** 7, Complete Independence (timely, safely) 6, Modified Independence (device) **Helper—Modified Dependence** 5, Supervision (subject = 100%) 4, Minimal Assistance (subject = 75% or more) 3, Moderate Assistance (subject = 50% or more) **Helper—Complete Dependence** 2, Maximal Assistance (subject = 25% or more) 1, Total Assistance (subject less than 25%) One of the biggest issues IRFs are having with the new 1–6 scale is that a patient's progression from level 1 to level 2 does not require a significant or meaningful amount of patient improvement and therefore overstates the patient's progress. As noted for the seven- level scale, a patient would have to put in at least 25% of the effort to move from level 1 to level 2, but any amount of effort between 1% and 49% on the six-level scale would signify a level 2. A second issue with the new scale is its inability to illustrate a patient's progress from using a device to not using a device, which the seven-level scale depicts with a progression from level 6 to level 7. By contrast, the new scale does not differentiate device usage within the various levels and therefore cannot illustrate functional improvement as a patient progresses from using a device to not using a device. Because of the difficulty of showing progress at the top end of the scale and the ease of showing progress at the bottom end, UDSMR and our subscribers are concerned that the values being reported in quality metrics are (1) inconsistent with the progress being made by patients and (2) inappropriately skewed toward potentially insignificant changes made at the bottom end of the scale. **5. The costs to the Medicare program attributable to implementing additional assessment items for measures that have not been found to be predictive of quality, cost, or payment need to be considered prior to implementation.** The implementation of new assessment items to meet the demand of quality measures for the IMPACT Act has come at a significant cost to providers, which ultimately will be passed along to the Medicare program. These costs	

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	manifest themselves in the form of additional staff education and training, additional administrative burdens to document and report on new items, and updates to existing forms or systems. Although these costs are expected for new programs, they are being expended on assessment items and quality measures that have not been fully tested in the venues they are being implemented in, that have not been approved or endorsed by any stakeholder body for implementation, and that have not shown any evidence of being predictive of quality, cost, or payment. Before additional costs are added to the Medicare program, UDSMR strongly recommends that RTI International and CMS weigh the burden being placed on providers for the proposed measures against whether the proposed measures have been fully vetted, are properly established prior to implementation, and truly represent quality. We appreciate both the opportunity to provide public comment and the careful consideration of the comments we have provided. We welcome the opportunity to work with you to provide ongoing research regarding the selection and implementation of standardized and interoperable quality indicators. If you have any questions about these comments or require additional information, please contact us at 716-817-7800.	
11/4/16	The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Many occupational therapy practitioners serve Medicaid and dual eligible (Medicare and Medicaid) beneficiaries in community based settings, outpatient settings, and post-acute care (PAC) settings. Occupational therapy practitioners provide medically necessary and skilled intervention to empower beneficiaries of Medicare post-acute care (PAC) services to live their lives to the fullest. AOTA is very pleased to provide feedback on the newly proposed quality measures related to self-care and mobility in skilled nursing facilities (SNF). **I. Background Information** Occupational therapy practitioners provide critical services to beneficiaries across post- acute care (PAC) settings, including SNF. The report states that "the primary goal of many SNF stays is improvement in function" (p. 1). While this may be true, it is also important to note that many SNF stays are also aimed at stabilizing beneficiaries' medical condition and maintaining their functional ability, as required by the Jimmo v. Sebelius settlement.[1] AOTA does agree that there is a need to standardize data collection across PAC settings. Data elements that capture performance and functional ability should be standardized where possible; however, care should be given to ensure that assessments used do not limit the collection of information that may be useful and unique for each setting.	Jeremy Furniss, OTD, OTR/L, BCG, CDP Director of Quality Division of Academic & Scientific Affairs American Occupational Therapy Association, Inc.

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	Functional status information, including ability to safely complete self-care and mobility tasks, is critically important during discharge planning. The background section identifies two general categories for discharge transitions: (1) home and (2) to another setting. AOTA would recommend that RTI specifically include long-term care at the same facility as a third category of discharge transition. Finally, AOTA appreciates the acknowledgement that other domains are important to measure in PAC settings. PAC rehabilitation and habilitation programs do indeed encompass domains including "function, activities, and participation" (p. 1). We can appreciate that the measures proposed in this document are not intended to be all inclusive, but are discrete constructs where RTI believes there to be sufficient evidence. [1] For more information about Jimmo, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf and http://www.medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/ AOTA supports the continued research in other domains specific to PAC rehabilitation and habilitation services. In addition to function, activities, and participation, functional cognition is one such domain which is critically important to measure and to integrate into case-mix consideration. AOTA understands that this is beyond the scope of the current project, but is eager to continue the discussion with CMS related to functional cognition. **II. Quality Measure: An Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)** AOTA supports the measurement of beneficiaries' ability to participate and complete self- care. Appropriately risk adjusted measures of this construct can meaningfully contribute to quality improvement if implemented correctly. AOTA appreciates the work of CMS and RTI in developing meaningful self-care measures. AOTA provides specific feedback on the Exclusion Criteria below. **a) Exclusion Criteria** ***Residents with incomplete stays.*** AOTA would encourage more specificity in the measure describing "residents discharged directly to another SNF". Some explanation in the implementation of the measure may be helpful. For example, would residents who are discharged to another SNF only under Medicare Part A qualify for this exclusion? Or, are residents who are discharged to another SNF for the purposes of long-term care also excluded? ***Residents who do not have an expectation of functional improvement.*** AOTA appreciates the inclusion of this exclusion criteria. For some residents, skilled SNF care is directed at stabilizing residents medically and preventing	

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	deterioration. These residents should not be included in the measure population. A more thorough discussion may be needed specifying how these residents will be identified on the MDS to ensure that they are not calculated in the measure. If RTI is proposing to exclude residents who do not have an expectation of functional improvement from the population retrospectively, a more detailed discussion on the variables used for exclusion may be helpful. **b) Items included in the Quality Measure** The items included in the measure represent the full self-care construct as identified in the analysis of the Continuity Assessment Record Evaluation (CARE) tool. As CMS works to standardize data elements across post-acute care (PAC) settings, integrating more elements from CARE can be helpful. However, AOTA cautions CMS to consider the burden of data collection and entry for facilities. As CMS looks to include these 7 data elements into the quality reporting system (QPS) for SNFs, the agency must also consider how section G of the MDS may or may not change. The 7 elements here utilize a unique scale, but gather similar information as data elements in Section G of the MDS. If the current data elements are removed, full consideration should be given to the ADL index that is currently used in Medicare and in some states Medicaid reimbursement structures. **c) Risk Adjustment** AOTA appreciates the effort and complications associated with risk adjusting for measures. These proposed measures are no different. In general, AOTA agrees with most of the risk adjustment variables. Specific questions of interest are noted below. **1. Variables included in risk adjustment** ***Primary Rehabilitation Diagnosis***—Risk adjusting based on rehabilitation diagnosis is logical. Mapping these diagnoses to ICD-10 would provide more complete information for this discussion. AOTA recommends that CMS continue to assess information based on diagnoses and update the measure as new categories are identified. AOTA recommends that hip and knee replacement diagnoses be separated by emergent and elective replacement surgeries. This differentiation may capture additional variation related to the health condition and acute care treatment leading to PAC. ***Cognitive Abilities: BIMS score***—Given the data that is collected and available in the MDS for risk adjustment, this variable is likely the best to capture variance in cognitive performance. However, AOTA would encourage CMS to consider updating this risk adjustment variable if new cognitive data elements are considered, in particularly variables explicitly addressing functional cognition. ***Comorbidities***—AOTA recommends that the following diagnoses be considered due to clinical importance in risk adjustment for self-care:	

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	• Lung and Other Severe Cancers • Lymphoma and Other Cancers • Other Major Cancers: Colorectal, Bladder, and Other Cancers; Other Respiratory and Heart Neoplasms; Other Digestive and Urinary Neoplasms; Other Neoplasms • Mental Health Disorders: Schizophrenia; Major Depressive, Bipolar, and Paranoid Disorders; Reactive and Unspecified Psychosis; Personality Disorders • Legally Blind • Major Fracture, Except of Skull, Vertebrae, or Hip • Transplant Status: Major Organ Transplant or Replacement Status; Other Organ Transplant Status **2. Potential missing variables for risk adjustment** ***Prior Functioning: Functional Cognition***—This variable is included in the two proposed mobility measures. The prior level of functional cognition is a difficult construct to measure at admission to a PAC setting. No current item on the MDS accurately reflects functional cognition at the time of assessment nor gathers information to measure the prior level of functional cognition. If RTI is proposing to utilize a proxy measure for prior functional cognition in mobility, it is clinically important to include this proxy as in risk adjustment for the performance of self- care as well. AOTA fully supports the development and inclusion of a data element to accurately measure functional cognition at the time of assessment. As discussed in Section I, AOTA is eager to work with CMS to develop a data element that would more accurately capture functional cognition. ***Total parenteral nutrition treatment***—This is another variable included in functional mobility that is not included in self-care. AOTA recommends consideration of including this variable in risk adjustment as it may capture variation associated with more complex medical condition prior to admission to the SNF. **d) Calculating Algorithm** The algorithm is logical to estimate a measure for risk adjusted improvement in self-care. AOTA would encourage CMS to consider comprehensive education to accompany these measures if they are implemented. Feedback to facilities will be key to provide adequate information for quality improvement at the facility level. To be meaningful for comparison across and within settings, the measure must be risk adjusted. To be meaningful to inform clinical improvement at the facility level, the measure should be simple. Unfortunately, these two criteria rarely exist in harmony. In the end, the QPS should encourage and facilitate quality improvement activities to impact the care received by beneficiaries. CMS can mitigate the complexity by providing comprehensive education with the new measure implementation and regular feedback as the measures are used.	

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	III. Quality Measure: An Application of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) AOTA supports the measurement of beneficiaries' ability to complete mobility. Appropriately risk adjusted measures of this construct can meaningfully contribute to quality improvement if implemented correctly. **a) Items Included in the Quality Measure** The mobility items from the CARE may also provide a significant increase to the burden of care for providers unless similar items are removed from the current MDS. AOTA fully supports the inclusion of the new items, but recommends that CMS consider aligning the remaining MDS items with the new items as quickly as possible. **b) Risk Adjustment** ***Primary Rehabilitation Diagnosis***—AOTA recommends that hip and knee replacement diagnoses be separated by emergent and elective replacement surgeries. More discussion is included in II(a). ***Cognitive Abilities: BIMS score***—Given the data that is currently collected and available in the MDS for risk adjustment, this variable is likely the best to capture variance in cognitive performance. However, AOTA would encourage CMS to consider updating this risk adjustment variable if new cognitive data elements are considered. ***Prior Functioning: Functional Cognition***—This risk adjustment variable is a difficult construct to measure at admission to a PAC setting. No current item on the MDS accurately reflects functional cognition at the time of assessment nor gathers information to measure the prior level of functional cognition. If RTI has identified a proxy variable to account for AOTA fully supports the development and inclusion of a data element to accurately measure functional cognition at the time of assessment. **IV. Quality Measures for Self-Care and Mobility Discharge Score** The recommendations discussed above in sections II for change in self-care and III for change in mobility apply to the discharge score self-care and mobility measures as well. AOTA supports measurement of self-care and mobility as these are critical constructs for PAC. While we are not against the utilization of the discharge score measures, we believe that the change in score measures may provide individual clinical settings information in a more actionable format to implement quality improvement activities.	

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11/4/16	This comment letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) in response to the Call for Public Comment on functional status quality measures that may be used in skilled nursing facilities (SNFs). The contract is titled *Development and Maintenance of Symptom Management Measures*, and the draft quality measures are: • An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633); • An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634); • An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and • An Application of the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). AMRPA is the national trade association whose members provide rehabilitation services across the spectrum of health care settings including inpatient rehabilitation facilities (IRFs), hospital outpatient departments (HOPDs), and settings independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, long-term care hospitals (LTCHs), and skilled nursing facilities (SNFs). AMRPA members help patients maximize their health, functional skills, independence, and participation in society so they can return to home, work, or an active retirement. Our IRF members on occasion discharge patients to the skilled nursing setting for further care. We appreciate the opportunity to comment on the proposed measures. IRFs have been reporting assessment data on self-care scores and discharge mobility scores on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) since October 1, 2016. We note that the draft SNF functional status measures are not being promulgated under the requirements of the Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014 in this request for public comment. Nevertheless, we believe that the various post-acute care (PAC) quality measures should be comparable across PAC settings and should be developed in a way that PAC stakeholders think is clinically accurate. We agree with CMS and RTI International that there is a need for "standardized assessment items" as well as the quality measures into which they feed.[1] AMRPA has reviewed the report prepared by RTI International, *Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities*, and we offer the following comments. **I. Measures Exclusion Criteria** The report proposes the same patient exclusion criteria for all of the SNF functional status measures. A majority of the exclusion criteria are identical to those in the IRF functional status measures. We offer comments on three criteria (#6-8 below) that were modified from the IRF measures' exclusions, presumably to accommodate the SNF resident population and/or SNF assessment practices.	Mimi Zhang Policy and Research Associate American Medical Rehabilitation Providers Association (AMRPA)

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	The draft patient exclusion criteria for the SNF functional status measures are: 1. Residents with incomplete stays. 2. Residents who are independent with all self-care activities at the time of admission. 3. Residents with the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; severe anoxic brain damage, cerebral edema, or compression of brain. 4. Residents younger than 21 years. 5. Residents discharged to hospice. 6. Residents who are not Medicare fee-for-services beneficiaries. Rationale: MDS data are submitted for Medicare fee-for-service beneficiaries. 7. Residents in swing beds in critical access hospitals (CAHs). Rationale: MDS data are not submitted for residents in swing beds in critical access hospitals. 8. Residents who do not have an expectation of functional improvement. Rationale: The focus of this measure is functional improvement for residents admitted to the SNF with an expectation of functional improvement. **A. Exclusions Based on Lack of MDS Data** AMRPA does not support limiting the SNF resident population to whom these measures apply to only Medicare fee-for-service beneficiaries. Medicare Part C, or Medicare Advantage, is a rapidly growing portion of the overall Medicare population, comprising 31 percent in 2016.[2] The size of this Medicare sub-population is significant and warrants their inclusion in quality of care measures. Furthermore, Medicare Part C beneficiaries are included in the IRF functional status measures. It is critically important that CMS prioritize cross-setting standardization as it develops and implements PAC quality measures. Hence, AMRPA believes that the measures should be applied to a uniform Medicare patient population that is inclusive of Medicare Parts A and C beneficiaries. We recommend that CMS require the MDS for all SNF Medicare residents, and include Part C SNF residents in the SNF Quality Reporting Program (QRP) requirements. Short of that, we recommend that CMS exclude Medicare Part C beneficiaries in the IRF functional status measures. We are concerned that these measures, rather than contributing to comprehensive and commensurate PAC quality reporting programs, could instead result in selective sampling of the patient population that would skew the collected data and distort or otherwise invalidate meaningful comparisons across measures and across PAC settings. For these same reasons, we recommend that CMS also require MDS assessments for swing-bed residents. Due to the geographical variability of PAC providers across the country, some CAHs with swing-beds may be admitting residents who are clinically similar to IRF patients. It is important for CMS to collect functional status assessment information on these types of swing- bed residents, as well as to overall monitor the quality of care delivered in these settings. [1] Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities – Public Comment Document, page 2. Prepared for CMS by RTI International. September 29, 2016. [2] Kaiser Family Foundation. May 11, 2016.	

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	B. Expectation of Functional Improvement The criteria propose to exclude SNF residents who do not have an expectation of functional improvement. Since all patients admitted to IRFs are expected to gain functional improvement, AMRPA agrees it is reasonable to apply the functional status measures to a limited and clinically-similar subset of SNF residents. However, as drafted, the proposal is unsettling, particularly if significant subjective judgment is involved regarding the beneficiaries in/out of the subset. We request that CMS provide more detailed information on methodology, how residents with an expectation of functional improvement would be identified, and how that data will be indicated/reported to CMS. For instance, will it be a provider-reported item added to the MDS? What safeguards will be in place to ensure valid reporting? The utility and value of PAC patient assessment data is its comparability across various settings. Without additional details, neither we nor other commenters are able to comment on the validity or appropriateness of this exclusion criterion, but we remain concerned about consistency, fairness, and objectivity of the collected data. According to our members' medical experts, an alternative and improved approach to identifying residents with an expectation of functional improvement could utilize risk adjustment to equalize the comparisons. A combination of risk adjustors that account for the level of impairment, functional status and co-morbidities, combined with relatively recent onset of impairment may be a more objective way to identify these types of residents. For example, the measure exclusion criteria – for all PAC providers – could exclude patients/residents with over three weeks of preceding acute care. In addition, another approach to identifying SNF patients with an expectation of functional improvement could include those patients who receive physical therapy, occupational therapy, and/or speech language therapy in the analysis. **II. Risk adjustment Methodology** The proposed risk adjustors for the SNF measures are also nearly identical to those used in the IRF functional status measures. Our comments focus on the "Primary rehabilitation diagnosis" risk adjustor. The draft specification report also refers to this adjustor as "Primary SNF rehabilitation diagnosis" or "Primary SNF Diagnosis Group." The proposed condition-based groupings under the "Primary rehabilitation diagnosis" risk adjustors are as follows: a. Stroke b. Non-traumatic brain dysfunction c. Traumatic brain dysfunction d. Non-traumatic spinal cord dysfunction e. Traumatic spinal cord dysfunction f. Progressive neurological conditions g. Other neurological conditions h. Fractures and other multiple trauma i. Amputation	

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	j. Hip and knee replacement (reference category) k. Other orthopedic conditions l. Cardiac conditions, pulmonary conditions, and debility m. Medically complex conditions n. Conditions requiring invasive mechanical ventilation With respect to the IRF functional status measures, they are risk adjusted for "Primary IRF Diagnosis Group" which is determined by the code entered in the IRF PAI Item 21, "Impairment Group Code (IGC)" during a patient's admission assessment.[3] Hence, the IRF diagnosis adjustor is based on a clinical code that is assigned to the patient after he or she is evaluated by a therapist or other clinician. However, the draft SNF measure report does not specify from where on the MDS 3.0 the "Primary rehabilitation diagnosis group" information would be derived – would there be a new assessment item for this data, or would it somehow be imputed from the SNF Resource Utilization Grouping (RUG) information? In other words, how would an IRF IGC-based risk adjustor apply to the SNF resident population? Furthermore, the report declines to specify what type of SNF clinician would make the assignment and how SNF residents would be categorized into the conditions groups. [3] RTI International, *Inpatient Rehabilitation Facility Quality Reporting Program: Specifications for the Quality Measures Adopted through Fiscal Year 2016 Final Rule*. Prepared for CMS August 2015. See pages 35, 43, 51, 59. Primary IRF Diagnosis Groups are specified as "Item 21. Impairment Group Code – Admission." AMRPA requests that CMS provide additional specificity and information on how a risk adjustor based on the listed Primary rehabilitation diagnosis groups would be implemented for SNFs. We think there needs to be a crosswalk between the IRF IGCs and SNF residents' diagnoses with respect to the functional status measures' risk adjustment. However, the draft specification report does not go into this level of detail. Without this level of granularity, neither AMRPA nor other commenters are able to provide adequate feedback on the appropriateness or clinical accuracy of utilizing the proposed Primary rehabilitation diagnosis group risk adjustors. CMS also included an additional Primary rehabilitation diagnosis group, "Conditions requiring invasive mechanical ventilation," for risk adjustment in the SNF functional status measures. This group is not included in the IRF measures. AMRPA recommends that CMS either also adopt this adjustor in the IRF measures' risk adjustment methodology, or remove it from the SNF measures' risk adjustment methodology. It is critical CMS ensures that the measures and their risk adjustment methodology produce an "apples-to-apples" and fair comparison of SNF residents and IRF patients. We reiterate our recommendation that the Agency and its contractors prioritize cross-setting comparability and objective data collection as they develop standardized quality measures for PAC settings.	

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	III. Summary AMRPA appreciates the opportunity to comment on the report Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities. In summary: A. We recommend CMS include Medicare Part C beneficiaries and swing-bed residents in the functional status measures by requiring MDS data for these types of residents. B. We urge CMS to provide additional specificity and information on the methodology by which SNF residents with an expectation of functional improvement would be identified and how that data will be indicated/reported to the Agency. As presented in the draft specification report, the definition of "expectation of functional improvement" has not been fully developed and needs clarity. C. We also recommend that CMS provide additional specificity and information on how it will implement the Primary rehabilitation diagnosis group risk adjustors for the SNF setting. D. We recommend that CMS adopt "Conditions requiring invasive mechanical ventilation" for risk adjustment in the IRF functional status measures, or remove it as a risk adjustor in the SNF functional measures. As CMS moves forward with measure development for all PAC settings, it is imperative to prioritize cross-setting comparability and alignment of measure specifications. If you have any questions regarding our recommendations, please contact Carolyn Zollar, J.D., Executive Vice President for Government Relations and Policy Development (czollar@amrpa.org), or Mimi Zhang, Policy and Research Associate (mzhang@amrpa.org) at 202-223-1920.	
11/4/16	The National Association for the Support of Long Term Care (NASL) is a trade association representing suppliers of ancillary services and providers to the long term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies that employ more than 300,000 physical therapists, occupational therapists and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in nursing facilities, as well as to beneficiaries in other long term and post-acute care settings. NASL members also include both vendors of health information technology (IT) that develop and distribute full clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers of assisted living, skilled nursing and ancillary care and services. Additional services and products provided by NASL members include clinical laboratory services, portable x-ray/EKG and ultrasound, complex medical equipment and other specialized supplies for the LTPAC sector. NASL is a founding member of the Long Term and Post- Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which was formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.	Cynthia K. Morton, MPA Executive Vice President National Association for the Support of Long Term Care

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	We are pleased to provide these comments on the "Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities." We appreciate that the deadline for comments was extended to November 4, 2016. <u>Comments Pertaining to all Four Measures:</u> 1. <u>Concern with the Risk Adjusters used in the measures:</u> NASL is concerned that PAC PRD data used to develop the risk adjustors in the draft measures are inadequate. The PAC PRD project included 34 nursing facilities and other providers, so the volume of data used to develop risk adjusters from these 34 facilities was small. Risk adjustors are an important part of a measure and developing risk adjustors requires a significant volume of data. While using risk adjustors developed from the PAC PRD may be a starting point for the draft quality measures on function, we recommend that CMS implement a process to reevaluate these risk adjustors on a regular basis for the purposes of ensuring their accuracy. As these measures are finalized and become operational, providers will be evaluated and penalized regarding their performance on these quality measures. Providers could face a skewed score on the measures if the risk adjustors are not accurate or functioning properly. As a result, providers could be penalized for lower scores on the quality measures as CMS works to ensure that the risk adjustors are properly constructed. We recommend that CMS recognize the limitations in the information that is known about the risk adjustors and ensure that CMS has a plan for continually evaluating them. If providers are penalized by lower scores on the quality measures and it is determined later that the risk adjustors included as part of the quality measure formula are faulty, then CMS must have a process for adjustment and rectifications. Public and stakeholder confidence in the quality measures should be high. We appreciate that RTI has utilized suggestions obtained from a technical expert panel (TEP) on risk adjustors. It appears these recommendations may not have been tested before posting in this proposal document. If the suggestions offered during the TEP were not tested with data, these need to be properly tested and vetted before becoming part of the quality measure and payment system. 2. <u>Concerns with "Expected" Results</u> Similar to our concerns with the risk adjustors, NASL is concerned with the "Expected" score within the Calculation Algorithm. If the risk adjustors are not accurate than an expected score built with the risk adjustors would not be accurate. For an expected score to act as a point of comparison, it needs to be accurate. Unless the risk adjustors have been tested we will not able to determine if the risk adjustors are appropriate until CMS has put them into use within the measures. We reiterate our understanding that reliability and accuracy are dependent on a large data sample. Once CMS has collected a large amount of data for a period of time, confidence in the findings could be secured. We should note that providers would be penalized for their performance on these measures at the same time that CMS is	

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	examining if the risk adjustors are appropriate. We recommend that a period of time be built in to evaluate the risk adjustors and other parts of the measure. It may be beyond the scope of RTI's contract, but we would be remiss if we did not ask if CMS is planning to collect the two years of data, then refine the measure and then apply the suspected penalty or incentive in 2019? We do not know if there is a plan in place but we would expect the initial phase to be a refinement period. Active and transparent communication with stakeholders should commence in order to further refine. We believe that CMS should have a process to further clarify and refine risk adjusters from those proposed by inclusion of omissions (such as the level and mode of patient communication as well as assessment for oral intake of patients using enteral feeding for swallowing disorders). We believe it is very important to delineate a process for refinement of the measures so that adjustments/corrections can be made. 3. <u>Risk Adjustors Based on Diagnoses in the Inpatient Rehabilitation Facility (IRF)</u> NASL is concerned that many of the risk adjustors listed for each measure are based on diagnoses that are frequently treated in the IRF. We are questioning whether these diagnoses truly apply to the SNF setting? These diagnoses need to be much more clearly defined and refined prior to the finalization of these measures. We recommend that the ICD-10 codes be listed and a clear definition for all diagnoses be provided for inclusion in quality measurement appropriate to the skilled nursing population. 4. <u>Concerns on Cognition, Communication and Swallowing Contained in the Risk Adjustors for Each Measure</u> Regarding cognition, we acknowledge the challenges in assessment of cognitive status of all patients. We are also aware of extensive efforts to assure Medicare beneficiaries are properly diagnosed and treated. To this end, we recommend that assessment of cognitive abilities include additional current cognitive assessments when they become available in the public domain. Regarding Communication: Understanding verbal content and expression of ideas and wants—To adequately and accurately determine the patient's needs through a standardized post-acute assessment process, the patient's level of communication as well as the method used to communicate are essential to quality care. As a result, we recommend a qualifier or gateway process to assure capture of mode and level of communication such as: • Mode: verbal or written or gesture or assistive device • Level: word or sentence or conversational Regarding Swallowing ability – We acknowledge the long term concerns with ongoing enteral feeding and the consequences this sometimes present. In an effort to assure accurate and appropriate quality care of those having used enteral feeding or assigned highly modified diets, we recommend a qualifier or gateway process to capture and	

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	align with the new Rules of Participation for Long Term Care Facilities to give evidence of assessment for PO status, such as: • Patient assessed for PO status and treatment recommended • Patient assessed for PO status and no treatment recommended • Patient to be assessed for potential to return to PO status 5. <u>Concern with Exclusions</u> Each measure excludes residents who do not have an expectation of functional improvement. The rationale stated is that the focus of this measure is functional improvement for residents admitted to the SNF with an expectation of functional improvement. We understand the intent to measure improvement of just the residents who can improve. NASL is concerned as to how RTI is obtaining information regarding residents who do not have an expectation of functional improvement? Is it your expectation that this information will come from Section G on the MDS? What if the patient's status changes after admission and they are able to functionally improve during the stay? To assure accurate and appropriate identification of beneficiaries within the full range of those serviced within the skilled nursing setting, we believe this exclusion needs more detail, refinement and further clarification of intent. 6. <u>Concern with Diagnosis and ICD-10 Coding</u> NASL is concerned as to where will the diagnosis group information come from? Would it come from the anchor/qualifying hospital stay? Or the MDS? Or the SNF claim? It is possible that these could theoretically be different. Furthermore, NASL is concerned with use of the ICD-10 coding. The use of ICD-10 coding is not a simple matter. The coding requires multiple levels of consideration and clinical input. There are often multiple medical diagnoses and therapy diagnoses for a single patient, for example. In some cases, nursing facilities have to rely on the ICD-10 codes that are sent by the hospital to initiate the Plan of Care and they often learn the diagnoses must be expanded or can later change during the skilled nursing stay. Professional coding is a specialty area that many hospitals are challenged to provide. The process of a skilled nursing facility being expected to use the hospital diagnoses and knowing that the diagnoses often need refinement, precision in hospital code information and the expectations for inclusion or exclusion for these quality measures becomes an exercise that must be refined and further defined prior to measure implementation. If ICD-10 codes are to be crucial to the measures, RTI may consider recommending to CMS that training be provided to nursing facilities in order to maximize the use of the ICD-10 codes. NASL recommends there should be more clarity on the diagnosis and the use of it in the measure so that it could be better defined as to what the expectation is of the nursing facility in fulfilling this aspect of the quality measure. 7. <u>Scoring of Activities</u> NASL is concerned regarding how missing values or activity not attempted values will be treated. Specifically, we are concerned about the following:	

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	In terms of the following Calculation Algorithms items for Measure 2.1 (p. 9): 1. Sum the scores of the admission self-care items to create an admission self-care score for each resident, after 'activity not attempted' values are recoded to 1 (score range: 7 to 42). 2. Sum the scores of the discharge self-care items to create a discharge self-care score for each resident, after 'activity not attempted' values are recoded to 1 (score range: 7 to 42) And for the following Calculation Algorithms items for Measure 2.2 (pp. 16-17): 1. Sum the scores of the admission mobility items to create an admission mobility score for each resident, after 'activity not attempted' values are recoded to 1 (score range: 15 to 90). 2. Sum the scores of the discharge mobility items to create a discharge mobility score for each resident, after 'activity not attempted' values are recoded to 1 (score range: 15 to 90). And for the following Calculation Algorithms items for Measure 2.3 (p. 23): 1. Sum the scores of the discharge self-care items to create a discharge self-care score for each resident, after 'activity not attempted' codes are recoded to 1 (score range: 7 to 42). This is the resident's observed discharge score. And for the following Calculation Algorithms items for Measure 2.4 (p. 31): 1. Sum the scores of the discharge mobility items to create a discharge mobility score for each resident, after 'activity not attempted' values are recoded to 1 (score range: 15 to 90). This is the resident's observed discharge score. --- This means that any item coded as one of the following "activity not attempted" options: • Code 07, Resident refused: if the resident refused to complete the activity. • Code 09, Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation, or injury. • Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.	

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	Will be recoded as: • Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity. We believe there appears to be an underlying assumption being built into the calculation methodology that "activity not attempted" equates to "dependent". Our concern is that such recoding (from an 07, 09 or 08, to an 01) will not accurately reflect resident status or change, as performance of an ADL task being refused, not applicable, or not attempted due to medical or safety concerns, does not necessarily mean the resident is dependent. For example, a resident may be coded as 03 (partial/moderate assistance) on admission, but as 07 (Resident refused) on discharge. The 07 would be recoded to 01 (Dependent) and make it look as though the resident got worse, when in fact the patient may be functioning at the same or a higher level for that ADL task. We also note that the reverse could also occur, overinflating actual improvement, if 07, 09, or 88 was coded on admission and coded at a higher level of function on discharge. Additionally, if 07, 09 or 88 are coded on admission and discharge, it again might not accurately reflect functional status and could look like there was no improvement because a dependent (01) code does not necessarily reflect actual functional ability. Finally, we raise the question of why there are options under "activity not attempted" if their meanings are not going to be considered. 8. <u>Other Concerns</u> NASL is additionally concerned about the following: • Lack of information about how providers will be held accountable if the goal changes during the episode. e.g. expectation for improvement is expected at admission, but due to a change in status, no more change is expected. Scores are only assessed at admission and discharge and not in between. • Use of the term "Primary rehabilitation diagnosis" does not recognize that not all patients are admitted for rehabilitation. • How is a medically complex condition (in risk adjustors) defined? • Where will information about mechanical ventilation be taken? From claims? From the MDS? Section O of the MDS only collects information if the patient was on ventilation in the 14 calendar days prior to admission, and does not differentiate between ventilation and respiration. • What is considered major surgery? • How is the interaction between primary diagnosis and SNF admission functional status determined? NASL appreciates the opportunity to provide these comments and stands ready to continue working with CMS and its contractors on these important issues. I can be reached at cynthia@nasl.org or 202 803-2385 for further information.	

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11/4/16	American Academy of Physical Medicine and Rehabilitation Position Statement: **Physiatrists Role in Skilled Nursing Facilities** Physiatrists have the knowledge and expertise to serve an important patient care and leadership role in all post-acute care (PAC) settings, including Skilled Nursing Facilities (SNFs). Physiatrists are optimally suited by way of the unique combination of medical and functional knowledge and expertise to achieve the highest functional outcome for patients at the least financial cost to our society. **Post-Acute Care Settings** Post-acute care is defined by CMS as care after an acute hospitalization that includes treatment in an Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), Long-term Care Hospital (LTCH) and Home Health Agency (HHA). The selection of the appropriate PAC setting for an individual patient largely depends on the diagnosis, functional status, expected gains in function and ability to participate in therapy, but there are several important non-clinical factors to consider. Some of these factors include geographic availability of various types of PAC settings, patient preference for a PAC setting close to home, home accessibility and level of caregiver assistance available at the time of discharge. The availability of funding is another important factor that influences the selection of PAC location. **Inpatient Rehabilitation Facilities (IRFs)** Inpatient Rehabilitation Facilities (IRFs) serve patients with complex rehabilitation needs and are highly regulated regarding patients admitted, physician involvement and the requirement for 3 hours of therapy per day. In 2014, there were about 1,180 IRFs in the United States and Medicare fee for service covered about 339,000 beneficiaries in 376,000 IRF stays.[1] There are increasing restrictions on IRF admissions and pressure to reduce the overall length of stay in IRFs to provide an efficient treatment program while maximizing functional outcomes. **Skilled Nursing Facilities (SNFs)** When patients have rehabilitation needs that do not require the intensity of interdisciplinary services provided in an IRF setting, they may benefit from a rehabilitation program to optimize recovery and functional outcomes in a SNF setting. Skilled Nursing Facilities are an increasingly important setting for provision of rehabilitative care in the United States health system, with more patients receiving rehabilitation treatment in SNFs than in hospitals and acute inpatient rehabilitation units. In 2014, about 15,000 skilled nursing facilities provided skilled care to 1.7 million patients and 2.4 million Medicare fee for service covered stays.[2] Skilled Nursing Facilities vary considerably in their ability to provide a rehabilitation treatment program. Rehabilitation in a SNF setting is often described as subacute rehabilitation, but subacute rehabilitation does not have a consistent definition and is not defined in Medicare or other regulations. Medicare does define criteria for designation as a skilled nursing facility. “Skilled nursing facilities (SNFs) provide short- term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech-language pathology services.”[3] Medicare will cover up to 100 days of SNF care after a hospital stay of at least 3 days. Medicare has detailed	Paul C. Smedberg Director, Advocacy & Government Affairs American Academy of Physical Medicine & Rehabilitation Washington, D.C. Office 801 Pennsylvania Avenue, N.W., Suite 255 Washington, D.C. 20004 202-420-5907

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	regulations regarding funding of a patient stay in a SNF. Medicare will cover SNF level care if all of the following are met: The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services; • The patient requires these skilled services on a daily basis and; • The daily skilled services can be provided only on an inpatient basis in a SNF. • The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.[4] Medicare goes on to define skilled services as when "the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel."[5] In addition it is expected that the medical record documents patient goals, the treatment plan, team coordination, the patient's progress toward achieving those goals and the ongoing need for skilled services.[6] Medicare does not specify the intensity of therapy services provided in a SNF and the attending physician is required to see the patient only every 30 days. **Physiatrists Role in SNFs** Physiatrists are medical specialists in Physical Medicine and Rehabilitation (PM&R) who have expertise in rehabilitation management and work to assure the highest quality of rehabilitative care in the most cost-effective manner so patients will achieve the highest level of functional ability and quality of life. Physiatrists have a well-established role in the leadership and medical management of IRF programs in medical centers and freestanding rehabilitation facilities. The role of the rehabilitation physician in the IRF is regulated by the Center for Medicaid and Medicare Services (CMS). CMS requires a rehabilitation physician, defined as a physician with specialized training and experience in rehabilitation services serve as the attending physician in the IRF setting. CMS regulations state, "A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services." [7] Physiatrists have historically had variable levels of involvement in SNFs, but physiatrists can serve an important role in this setting to help assure the highest quality outcomes and the most efficient use of resources. Physiatrists, by virtue of their training, experience and knowledge of rehabilitation, impairment and function have the unique qualifications and expertise to be the leader of the SNF rehabilitation team. In the ideal situation, a physiatrist in a SNF setting will serve in a consulting or co-treating physician role and visit the patient two to three times a week depending on the needs of the patient. Physiatrists can also serve as the SNF medical director and/or be the attending physician in some	

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	situations. Patients receiving a SNF rehabilitation level of care don't need the daily physician visit of patients receiving an IRF level of care, but their rehabilitation requires more frequent physician oversight than that mandated for primary attending physicians in SNF settings. Close communication with the primary attending physician is essential for high quality patient care. The physiatrist will not just track the medical status of the patient but will track and document the patient's functional status demonstrating progress toward goals and identifying barriers to reaching functional goals. Physiatrists will also provide medical services such as treatment of spasticity or pain that is limiting functional gains and will make recommendations for further medical evaluation and treatment. When clinically appropriate, they will additionally identify and prescribe adaptive or assistive devices for safety and to further facilitate function. To expand the role of physiatrists in SNF settings it will be necessary to educate SNF staff on all aspects of the rehabilitation model of care with which they may not be familiar. This includes education on the need for coordinated, physician led rehabilitation treatment that includes weekly team meetings to discuss the patient's functional status, barriers to discharge, expected length of stay and other factors. A focus on setting functional goals and utilizing an evidence-based model for rehabilitation treatment while including patient and family engagement and factoring in patient and family goals and expectations is also important. As the leader of the SNF rehabilitation team, the physiatrist will set functional goals for the patient and closely monitor the progress toward those goals and barriers to achieving the goals. The physiatrist will also set the discharge goals and will work to manage the patient stay and facilitate the transition to the next setting in a timely manner. The physiatrist must also work with the SNF administration, nursing and therapy leadership to monitor the quality of rehabilitative care in the SNF, performance improvement and work with funding agencies to determine the appropriate level of care. **Conclusion** There is increasing pressure in the healthcare system to provide high quality, efficient rehabilitation care to patients across PAC settings including SNFs. In the future, more patients will be receiving their rehabilitation care in a SNF setting. Physiatrists have unique expertise and should take an active role in this setting. Physiatrists will focus on the coordination of the rehabilitation team, set functional goals, manage medical and other complications related to the rehabilitation diagnosis, minimize hospital readmissions, and work to transition the patient to home as quickly and safely as possible. The physiatric management of patients in the SNF setting will lead to greater functional gains by the patient, earlier discharge and cost savings for the healthcare system. REFERENCES [1] MedPAC Report to the Government, March 2016, Medicare Payment Policy, Chapter 9, page 237 (available online at http://www.medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=2).	

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	[2] MedPAC Report to the Government, March 2016, Medicare Payment Policy, Executive Summary, page xvi (available online at http://www.medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=2). [3] MedPAC Report to the Government, March, 2016, Medicare Payment Policy, Chapter 7, page 179, (available online at http://www.medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=2). [4] Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 30 (available online at https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/Downloads/bp102c08.pdf). [5] Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 30.2.2 (available online at https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/Downloads/bp102c08.pdf). [6] Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 30.2.2 (available online at https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/Downloads/bp102c08.pdf). [7] Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 110.2.4, (available online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf). --- The American Academy of Physical Medicine and Rehabilitation (AAMP&R), the society that represents more than 9,000 physiatrists, appreciates the opportunity to submit comments on the draft specifications for the functional status quality measures for skilled nursing facilities. 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. **Appropriateness of Measures in the Skilled Nursing Facility (SNF) Setting** In general, AAPM&R believes the draft specifications for functional quality measures for skilled nursing facilities and the overall effort represents a step in the right direction for post-acute rehabilitation. Specifically, the document recognizes the need to level the playing field across rehabilitation providers utilizing the Continuity Assessment Record and Evaluation (CARE) Item Set. While we see some positive changes in the draft specifications we want to take this opportunity to emphasize the importance of comparing similar (and equivalent) skilled nursing facilities and in-patient (rehabilitation) facilities outcomes fairly because they may highlight some differences in certain areas of care. AAPM&R believes it is appropriate to apply self-care and mobility measures to skilled nursing facilities. As mentioned in the report, while self-care and mobility are very important indicators of successful rehabilitation, other dynamics – especially cognitive issues – must be addressed or real patient independence cannot be ascertained. For example, a patient who is able to become fully independent in self-care and mobility, but is unsafe to live independently due to	

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	cognitive deficits, might be considered to have a 'good' quality outcome under the proposed draft specifications. As more neurological patients are being driven to rehabilitation care in the skilled nursing facility setting, this has been becoming a bigger determinant of outcome and should be addressed by CMS. We agree with the report that additional research is needed to develop quality measures for other areas of functional status. AAPM&R believes the list of quality measure exclusions for skilled nursing facilities is reasonable. **Ease of Incorporation to Skilled Nursing Facilities** As we stated earlier, AAPM&R believes the draft specifications for functional quality measures for skilled nursing facilities and the overall effort represents a step in the right direction for post-acute rehabilitation. There is however one area that was not addressed in the report when considering ease of incorporation to skilled nursing facilities. We would be remiss if we did not mention the burden of new data measures on staff members and patients. Any change in the data collected will require early and substantial training of staff members if CMS expects this effort to result in the collection of meaningful data. AS CMS adds new measures for skilled nursing facilities to collect, AAPM&R urges that CMS conduct a review of current measures and delete any items that duplicate or overlap with measures being added. **Comments on Risk Adjustment** While we appreciate risk adjustment(s) being addressed in the report, AAPM&R finds it difficult to provide substantive comments because important detail on risk adjustment proposals is not provided. We request that CMS provide a more detailed methodology so we can submit thoughtful comments at some future time. We do however want to provide some general comments to CMS as you consider refinements to the risk adjustment section. • Consider adding a stay of three weeks or more in an acute hospital risk factor. A stay of three weeks or more generally indicates there are special patient needs or problems to manage. • The addition of invasive mechanical ventilation risk factor seems reasonable, but it should also exist for in-patient rehabilitation facilities. • AAPM&R recommends a cross walk between the In-Patient Impairment Code Group and the Skilled Nursing Facility Measures in the risk adjustment section for skilled nursing facility patients. **Other Comments** Since skilled nursing facilities only report on Medicare fee-for-service, AAPM&R recommends that CMS include data and information on beneficiaries not in the fee-for-service program as analysis of recommendations and refinements to the program move forward. As more Medicare beneficiaries are driven to Medicare Advantage plans, we are	

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	concerned that the fee-for-service Medicare data will become less relevant. Holding managed care plans accountable for obtaining a reasonable level of functional outcomes will become increasingly important as this process advances. CMS needs to recognize the needs of patients who are not a fee-for-service beneficiary. In the effort to collect data across post-acute care settings, standardizing patient assessment data amongst Post-Acute Care (PAC) settings is important work that greatly impacts AAPM&R's members. In an effort 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 Governors in June 2016. This document is intended to show our support for moving towards standardizing data elements across PAC settings as long as 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. AAPM&R also wants to highlight the effect physiatrist leadership of the skilled nursing facility has on patient outcomes. Unfortunately, the importance of coordinated rehabilitation medical care was not mentioned in the introductory section of the report. ***American Academy of Physical Medicine and Rehabilitation Position Statement: Physiatrists Role in Skilled Nursing Facilities*** details the expertise physiatrists have to lead patient care across post-acute care settings. This position was approved by AAPM&R's Board of Governors in June 2016. It is intended to explain how and why physiatrists are optimally suited by way of the unique combination of medical and functional knowledge and expertise to achieve the highest functional outcome for patients at the least financial cost to our society across post-acute care settings. We appreciate the opportunity to comment on the Draft Specifications for the Functional Status Quality Measures for Skilled Nursing Facilities Report. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Paul C. Smedberg, Director of Government Affairs & Advocacy at PSmedberg@aapmr.org or at (202)-420-5907. **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	

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	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;*	

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	• *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 o 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. o 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 o General Mental status including alertness and orientation o Evaluation of memory, attention, concentration	

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	○ 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 <u>Future Quality Measurement of PAC Services</u> 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.	

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Out of scope comments		
10/13/16	The CMS Star rating doesn't punish the current administrators who are getting poor scores, its punishing Administrators who have to come in behind them, and clean up the previous administrator's mess. When administrators get poor scores on CMS Star rating, it takes the next administrator 3 years to improve the scores, and that's not fair. The new administrator then has a hard time building census because of the competition using the star ratings against them.	Richard Broom
10/25/16	Please seriously consider including Recreational Therapy in the Skilled Rehabilitative Modalities for this setting.	Tim Passmore, Ed.D., CTRS/L, FDRT Chair, Therapeutic Recreation Committee Oklahoma Board of Medical Licensure & Supervision Secretary, National Academy of Recreational Therapists Fellow, Distinguished in Recreational Therapy Associate Professor Area Coordinator, Recreation Management & Therapeutic Recreation Graduate Coordinator, Leisure Studies School of Applied Health & Educational Psychology College of Education Oklahoma State University