



ASHA
American
Speech-Language-Hearing
Association

August 11, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1766-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the calendar year (CY) 2023 home health (HH) prospective payment system (PPS) proposed rule.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. ASHA estimates that 8,000 members who are speech-language pathologists (SLPs) work in home health.¹ Our comments focus on CMS's efforts to uphold budget neutrality in the home health payment system and collection of data associated with the use of telecommunication technologies in home health.

II.B. Proposed Provisions for CY 2023 Payment Under the HH PPS

SLPs provide critical therapeutic communication, swallowing, and cognitive services to patients in their home. ASHA is concerned about the impact of proposed budget neutrality payment adjustments on access to medically necessary care, as well as ASHA members' ability to use their clinical judgment to treat home health patients.

For the second year in a row, CMS provided data to show the divergence between its estimates for the cost to deliver care and reimbursement compared to actual cost and reimbursement resulting from the industry's implementation of the Patient Driven Groupings Model (PDGM) payment system on January 1, 2020. ASHA appreciates CMS's recognition that analyzing the data is complicated by the simultaneous impact of COVID-19, and that it delayed any negative payment adjustment as part of the CY 2022 rulemaking cycle to help gain a better understanding of the impact of these two significant changes in HH service delivery. However, changes in service delivery patterns in 2020—as identified in the 2022 proposed rule—are alarming and that trend seems sustained and reinforced by 2021 data in the 2023 proposed rule. CMS states that in 2021 the average number of HH visits provided dropped 16% and that Medicare reimbursements to HH agencies were approximately 34% higher than the cost of delivering care.

Evidence of these trends are also reinforced by ASHA member reports of administrative mandates including, but not limited to:

- restricting the number of visits using predictive analytic tools,
- determining patients with specific assessment tool scores were not eligible for services, or
- indicating that patients did not have a “qualifying” therapy diagnosis, therefore, were not eligible for therapy.

In addition, beginning in 2019, before the implementation of PDGM, many SLPs were laid off or saw a reduction in hours, wages, and/or benefits. According to ASHA’s 2021 membership survey, 31% of survey respondents working in HH indicated their caseload has been reduced, 12% of survey respondents indicated they were considering a career change because of unstable hours, 11% of respondents noted they were pressured by their employer to discharge a patient inappropriately (either early or late), and 11% of respondents noted they were forced to provide inappropriate frequency or intensity of services.² ASHA will have updated survey data in 2023 to determine if these trends have been sustained.

ASHA recognizes that CMS has an obligation to ensure patient access to and safety of care and must be a good financial steward of the Medicare trust fund and, as a result, has proposed to implement a budget neutrality adjustment. While ASHA further recognizes a budget neutrality adjustment may be justified based on the data outlined in the CY 2023 proposed rule, ASHA urges CMS to proceed with caution to ensure that HH agencies that **did not** curtail access to care or inappropriately manipulate the payment system **do not** withstand the worst of these reductions. In addition, ASHA is concerned that a blunt, across the board payment reduction will not meet CMS’s goal of achieving regulatory compliance and budget neutrality. Given our members’ experiences during the transition to PDGM and CMS data, ASHA expects many HH agencies will further reduce therapy delivery; thereby, restricting access to care at the detriment of Medicare beneficiaries. ASHA recommends that CMS determine if there are specific trends in Outcome and Assessment Information Set (OASIS) and claims data would allow CMS to target the application of a budget neutrality adjustment to individual HH agencies that did not comply with its regulatory and budget neutrality expectations. This would help mitigate the negative budgetary impact across the entire industry.

ASHA is also concerned about the striking omission of data associated with quality and outcomes of care for Medicare beneficiaries in HH agencies in this proposed rule. In comparison, since implementation of the skilled nursing facility (SNF) Patient Driven Payment Model, CMS staff has examined a variety of quality metrics including cognitive decline, hospital readmissions, and falls, to gain a better understanding of what changes in service delivery during the payment system transition meant for Medicare beneficiaries. In some cases, a reduction of service delivery led to poorer health outcomes for Medicare beneficiaries treated in SNFs. It would be inappropriate to move forward with a budget neutrality adjustment without understanding and preparing to address the impact on Medicare beneficiaries from implementing a payment reduction for HH agencies.

ASHA questions the suitability of a budget neutrality adjustment when the clinical complexity of patients—as represented by the level of functional impairment and comorbidities—appears to have increased, yet the number of visits provided to patients has dropped. This counters clinical expectations and must be better understood. ASHA maintains that several factors explain the increased reporting of functional impairment and comorbidities including, but not limited to, the impact of COVID-19 and the recognition of these factors for reimbursement. Specifically, the previous HH payment system provided reimbursement based on the number of HH visits

provided rather than patient characteristics. PDGM appropriately changed this reimbursement methodology by reimbursing based on the clinical complexity and the needs of the patient. In other words, HH agencies were reimbursed for accurately and comprehensively recording patient clinical characteristics on the OASIS and claims, which led to a higher reporting of functional impairment and comorbidities. It is critical for CMS to continue monitoring this data to determine if the medical record supports the information reported via the OASIS and claims, and to ensure that therapy services are delivered when clinically indicated for the patient.

ASHA has identified additional trends from the proposed rule that require further examination. These findings may lead to additional refinements to PDGM and may be used to mitigate the degree of any future budget neutrality adjustment. These trends include the timing of episodes of care (early and late), the source of admission (community or institutional), the level of functional impairment, the comorbidity adjustment, and the number of patients who received little or no therapy.

1. Timing of Episodes and Source of Admission

Table B8 of the proposed rule highlights the percentage of patients admitted from the community or an institution as well as the timing of the episode as either early or late. In the development of PDGM, CMS believed it needed to 1) ensure appropriate payment based on actual cost associated with the source of admission and 2) address the significant differential between community and institutional admissions (approximately 75% to 25% respectively).. As a result, CMS developed these payment differentials. But it does not seem to have had an impact on the source of admission. ASHA recommends that CMS should determine why there has not been a change in the source of admission, including the impact of COVID-19 in which many patients were not receiving institutional care to mitigate the risk of transmission.

To prevent HH agencies from “cherry picking” patients to maximize profits, it is critical to understand the impact of such payment differentials on agency behavior. ASHA has expressed concern regarding the potential unintended consequence of this policy choice in previous comments. For example, community admissions are “lower cost” based on historic Medicare data. ASHA recommends that CMS determine if some HH agencies are keeping community admissions on for a late episode to maximize reimbursement even when it is not clinically indicated for the patient. On the other hand, because of lower reimbursement for community admissions, CMS should determine if those patients are being “avoided” by some health agencies because they aren’t seen as “profitable.” Historical Medicare data has shown that institutional admissions tend to be “more costly;” therefore, ASHA recommends that CMS determine if HH agencies are disproportionately discharging institutional admissions within the first 30 days to control their costs. ASHA urges CMS to analyze the data associated with this element of the PDGM reimbursement methodology to ensure patient access to care is not jeopardized.

While the data in Table B8 does not show a significant divergence from CMS’s estimates, understanding the discrepancy between the anticipated to actual behavior is needed to determine if the budget neutrality adjustment could be modified to avoid inappropriately penalizing some HH agencies. If such trends are identified, ASHA recommends CMS determine if an enforcement mechanism may be imposed to ensure patients are selected based on need and in compliance with Medicare regulatory requirements (e.g., homebound) rather than the financial benefit associated with a particular patient profile.

2. Level of Functional Impairment

PDGM creates a payment differential for each level of functional impairment: low, medium, and high. This is a key component of the payment system to ensure cost and resource use are appropriately recognized and reimbursed. However, as shown in Table B9 of the proposed rule, the number of patients with a high level of functional impairment exceeded CMS's estimates by approximately 13%. CMS data shows that fewer patients had a low level of functional impairment than CMS estimated. CMS expected approximately 34% of patients would have a low level of functional impairment but, in 2021, 23% of patients had a low level of functional impairment. As noted above, the decrease in visits and cost with an increase in comorbidities and higher levels of functional impairment must be better understood. This may be due to the appropriate financial incentive to reflect this information more accurately. However, if CMS identifies specific HH providers who have indicated a high level of functional impairment for the purpose of reimbursement, CMS may target these providers to further refine the level of a budget neutrality payment adjustment in future years.

3. Comorbidity Adjustment

ASHA notes that in Table B7 of the proposed rule, the percentage of patients for whom it provided a comorbidity adjustment of low to none was smaller than CMS estimated while the percentage of patients who received a high comorbidity adjustment was higher than CMS estimated. CMS estimated that the percentage of patients who would not trigger a comorbidity adjustment would be 52% but, 49.6% had no comorbidity adjustment. In addition, CMS estimated that only 10% of patients would trigger a high comorbidity adjustment, but 2021 data showed that 13.5% of patients triggered this adjustment. While the differences in these projections might not be considered significant, this requires further examination. It may be that the recognition of comorbidities provided a proper financial incentive for HH agencies to report this data. But ensuring that the medical record supports this to refine the potential budget neutrality adjustment is critical to ensure those providers who are not complying with CMS's expectations are most impacted by a future payment adjustment.

4. Therapy Provision

Since CMS first introduced HH payment reform in 2017, ASHA has supported the development of a patient-centered payment model but has had conveyed significant concerns that it would inappropriately reduce the delivery of speech-language pathology services. ASHA appreciates the numerous efforts CMS has made to ensure that all stakeholders recognize the critical value of therapy services, including speech-language pathology services. By making statements to this effect in previous rulemaking as well as an Medicare Learning Network (MLN) Matters article, CMS helps reinforce the value of therapy and the importance of providing all medically necessary services to HH patients.³ ASHA has engaged in a significant member advocacy campaign to educate SLPs—who are working in HH—about the unique value of their services to ensure the needs of their patients are met, and to help ensure that they stay in compliance with Medicare requirements for service delivery. ASHA has also engaged physician and patient advocacy organizations to make sure they understand that therapy remains a critical element of the HH payment system.

Despite these efforts, ASHA members have reported that administrative mandates often drive care decisions instead of their patients' needs and their clinical judgement. In some cases, facilities and administrators use predictive analytics to dictate the number and frequency of visits contrary to the clinical recommendations of the evaluating clinicians. SLPs are often told that they are not allowed to provide certain types of therapy services (e.g., cognitive therapy) or provide services to patients who do not have a diagnosis that triggers an additional payment. Unfortunately, ASHA believes the the data presented in Table B10, and Figure 3 of the proposed rule reinforces ASHA members' experiences.

Nearly 40% of HH patients received no therapy. In addition, CMS data shows that during many 30-day periods of care, patients receive 4 therapy visits while the proportion of 30-day periods of care that received 12 therapy visits fell far short of CMS's expectations. In other words, Medicare beneficiaries received far fewer therapy visits than under the previous payment system. ASHA recommends that CMS should determine if limiting the therapy visits by a subset of HH providers has skewed the data in a way that inflates the perceived level of a budget neutrality adjustment.

ASHA strongly recommends that CMS determine if a therapy payment is being triggered through the completion of the OASIS while the therapy provision is inappropriately reduced or may not be provided at all. The HH agencies that consistently receive a therapy payment but fail to provide the appropriate therapy services must be held accountable to maintain access to care and mitigate the impact of a budget neutrality payment adjustment.

In summary, if CMS's data are accurate, it may reflect that a portion of the industry responded to changes in the payment system by administratively restricting service delivery. It is possible that a budget neutrality adjustment would stimulate a similar response from the industry. This response would further restrict access to care for Medicare beneficiaries instead of ensuring compliance with Medicare requirements. **ASHA urges CMS to consider the full range of factors that may have contributed to the HH industry's departure from its budget neutrality expectations and identify ways in which a payment adjustment may be refined, targeted to HH agencies that have violated the payment system's regulatory requirements, and mitigated to ensure patient access to clinically indicated and appropriate therapy services.**

K. Comment Solicitation on the Collection of Data on the Use of Telecommunications Technology under the Medicare Home Health Benefit

ASHA is committed to ensuring Medicare beneficiaries enjoy the same access to telehealth services as many of their peers enrolled in Medicaid, Tricare, and private insurance plans on a permanent basis. ASHA recognizes that several provisions of federal law preclude coverage of Medicare telehealth services outside the circumstances of the federal public health emergency (PHE) and that even in the context of the PHE, federal law requires services provided under the HH prospective payment system to be provided in person. ASHA appreciates that CMS allowed telehealth services to be accounted for in the cost per visit and that while telehealth services could not replace in-person services they could still be provided when clinically appropriate as a supplement to in-person care. ASHA agrees that additional data around telehealth utilization in HH is necessary to help make effective policy choices moving forward and is pleased to respond to the request for information (RFI) included in the proposed rule.

ASHA notes there are mechanisms for reporting such information on claims at CMS's disposal and does not support the development of new or differing G codes for this purpose. However,

as described in the RFI, ASHA requests CMS clarify if it is talking about communication technology-based (CTB) services (e.g., virtual check-ins, e-visits), telehealth services as represented by Current Procedural Terminology (CPT®) codes and modifiers, or both. ASHA supports data collection on both CTB and telehealth services and recommends CMS use the existing mechanisms available for reporting this information on claims. For CTB services, SLPs can report the following codes on claims in 2022 and 2023.

- **98970:** Qualified nonphysician healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- **98971:** Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
- **98972:** Qualified nonphysician qualified healthcare professional assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
- **G2250:** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment
- **98975:** Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
- **98976:** Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
- **98977:** Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
- **98980:** Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes
- **98981:** Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (listed separately in addition to code for primary procedure)

In addition, SLPs can report any CPT code on the CMS authorized telehealth services list that would normally be reported for in-person services by using modifier 95 to indicate telehealth services during the federal public health emergency.

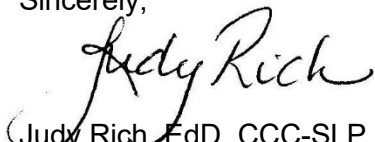
By collecting data based on CPT codes for CTB and telehealth services, CMS should be able to achieve its goal of better understanding what types of virtual services are being provided to HH patients without developing a new code set. Having one code set to represent services provided under Part A and a separate code set for services provided under Part B would be administratively burdensome and complex. It would also prevent CMS from effectively

comparing data across practice settings. In addition, because CMS indicates it plans to require revenue codes in updates to Chapter 10 of the Claims Processing Manual, it does not seem necessary to develop separate codes to try to identify the type of clinical service provider who delivered the telehealth service. Individual CPT codes are typically used by specific types of providers so CMS would have a fair understanding of who provided the service based on the CPT code billed. For example, 92507 is a code typically used by SLPs. If that code were to appear on the HH claim with the -95 modifier, CMS could assume it was provided by an SLP.

ASHA supports CMS's proposal to begin using codes to track virtual services on January 1, 2023, but waive any penalty or enforcement until July 1, 2023, to allow HH agencies time to make the requisite updates to their electronic health record and/or claims processing systems, train staff, and implement effective processes for complying with these requirements.

Thank you for the opportunity to comment on this proposed rule. If you or staff have any questions, please contact Sarah Warren, ASHA's director for health care policy for Medicare, at swarren@asha.org.

Sincerely,

A handwritten signature in black ink that reads "Judy Rich". The signature is written in a cursive, flowing style.

Judy Rich, EdD, CCC-SLP, BCS-CL
ASHA 2022 President

¹ American Speech-Language-Hearing Association. (n.d.). *ASHA Membership Survey*. <https://www.asha.org/research/memberdata/membership-survey/>.

² *ibid*

³ Centers for Medicare & Medicaid Services. (2020) *The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)*. <https://www.cms.gov/files/document/se20005.pdf>.