AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

August 30, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS–1689–P
Mail Stop C4–26–05
7500 Security Blvd.
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to comment on the proposed rule for the home health prospective payment system for calendar year (CY) 2019.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

The proposed rule creates a new payment system, the patient driven groupings model (PDGM), for implementation in 2020. The PDGM represents a fundamental shift in payment for therapy services (e.g., speech-language pathology services) and will have a significant impact on ASHA's members. ASHA has been engaged in the development of the PDGM and is committed to ensuring meaningful access to and equitable reimbursement for speech-language pathology services as required by the Bipartisan Budget Act of 2018 (P.L. 115-123). We appreciate the efforts of the Centers for Medicare and Medicaid Services (CMS) to engage stakeholders, including ASHA, as the PDGM evolved.

ASHA's comments focus on the following areas:
1. Developing a Payment Model that Transitions to a Value-Driven Health Care System
2. Providing Payment Based on 30-Day Episodes
3. Identifying Conditions and Comorbidities that Drive Payment
4. Determining the Data Source: Bureau of Labor Statistics or Cost Reports
5. Coordinating on the Development of a Unified Post-Acute Care Prospective Payment System
6. Developing an Accountability Mechanism to Ensure Therapy Services are Delivered
7. Implementing a Split Percentage Payment Approach for a 30-Day Unit of Payment

Developing a Payment Model that Transitions to a Value-Driven Health Care System

During the February, 2018, technical expert panel (TEP) meeting, clinicians and industry experts, including ASHA members, emphasized the dramatic changes to our health care system. Providing health care in the patient preferred setting—often their place of residence—and avoiding hospitalization and re-hospitalization are critical aspects of health care delivery reform. Additionally, patients who previously required institutionalization, such as those receiving a joint replacement, are often transferred home on the same day as the procedure without admission to the hospital. Many alternative payment models are working to identify the most efficient and effective care trajectory for patients, which could mean bypassing hospitalization or admission to another post-acute care setting instead of treatment in the patient's home. Modifying payment based on source of admission to home health runs counter to meeting beneficiary needs and does not reflect trends for delivering health care in the most effective and efficient ways.

ASHA maintains that it is counterproductive to devalue admissions to home health from the community as these admissions often prevent hospitalization or re-hospitalization and provide medically necessary health care in the beneficiary's preferred setting. ASHA believes decreased reimbursement for admissions to home health from the community is inappropriate. CMS must consider the impact such a policy would have on the selection of the most appropriate care settings for patients and the resulting effect on related costs and outcomes.

Providing Payment Based on 30-Day Episodes

Data presented during the February TEP meeting showed changes in the frequency and intensity of some health care services provided. For example, physical therapy is often provided more frequently and intensively within the first 30 days and then reduced over the subsequent 30 days of the 60-day episode. However, speech-language pathology services are delivered consistently over the entire 60-day episode. Because the frequency and intensity of speech-language pathology remains consistent over 60 days, ASHA opposes "dividing" the payment differently between the first 30-day and second 30-day episode for speech-language pathology services. Front-loading payment for the first 30 days and reducing payment for the next 30 days could discourage service delivery in the second 30-day period. In addition, a payment variance during a 60-day episode, as proposed, would disproportionately affect Medicare beneficiaries needing speech-language pathology services.

ASHA requests that payment for speech-language pathology services be provided consistently over each 30-day episode (e.g., 50/50) to support Medicare beneficiaries with a clinical need for consistent service delivery across the full episode of care.

A similar approach for providing consistent reimbursement for speech-language pathology services was adopted for the patient driven payment model (PDPM) and applicable to skilled nursing facilities (SNF). In the PDPM, the variable per diem rate that was only applied to physical and occupational therapy services and non-therapy ancillary services (NTA) as opposed to all services provided in the SNF. ASHA recognizes the units of payment (per diem vs. episode) are different, which makes a comparison somewhat challenging. However, it is concerning that a lower payment for late episodes discourages additional 30-day episodes even when that is in the clinical best interest of the patient.

Identifying Conditions and Comorbidities that Drive Payment

As currently structured, the conditions and comorbidities that CMS has selected for payment purposes do not adequately reflect all of the roles speech-language pathologists (SLPs) have in

treating patients. In the proposed rule, only two clinical categories, musculoskeletal rehabilitation and neuro/stroke rehabilitation, include speech-language pathology services. However, SLPs play a role in other clinical categories within the PDGM including complex nursing interventions, behavioral health care, and medication management teaching and assessment (MMTA). Following are some examples of an SLP's role for each category:

- **Complex nursing interventions with enteral nutrition and ventilators**: SLPs often assist with the development or modification of diet regimens to address issues with swallowing liquids and/or foods. SLPs work with the health care team to assist in weaning patients from ventilators to avoid the development of pneumonia and/or other complications.
- **Behavioral health care**: SLPs provide cognitive treatment services for patients with dementia or similar conditions.
- **MMTA**: SLPs often assist is the identification of cognitive deficits that could impact a patient's ability to manage their medications.

ASHA requests that CMS clarify that speech-language pathology services are expected to be delivered to any patient who requires such services across all clinical categories.

Determining the Data Source: Bureau of Labor Statistics or Cost Reports

An active topic of discussion during the February TEP meeting was whether to base payment on Bureau of Labor Statistics (BLS) data or cost report data. Nearly everyone agreed that cost report data is currently inadequate because there is no mechanism in place to ensure uniform completion (e.g., a manual or standardized process across the industry), and there is no audit for accuracy. While BLS data, which is currently used, is also not audited there is a standardized process associated with the data. Without a standardized process, cost report data is a poor source of information to base payment on. For example, on cost reports nurse administrators might be included in the cost reporting category for administration or nursing costs, potentially creating inaccurate perceptions about the true cost of nursing services. ASHA encourages CMS to consider standardizing the process of cost reporting first and then moving to audited cost reports at a later date when sufficient and accurate information is available.

Coordinating on the Development of a Unified Post-Acute Care Prospective Payment System

The metrics and items collected as required by the Improving Post-Acute Care Transformation (IMPACT) Act, in the current home health prospective payment system and the PDGM system are duplicative and burdensome because they require the same information twice or in slightly different ways. ASHA is committed to ensuring quality metrics in the home health payment system to protect beneficiaries from stinting on care while achieving CMS' goal of developing and fielding a crosscutting value-driven payment model. CMS should consider how it can harmonize items and eliminate duplication whenever possible.

Additionally, a change as substantial as the PDGM or a unified payment system requires time (e.g., modifying electronic billing and documentation software) and provider education for successful implementation. ASHA is concerned that CMS might transition to the PDGM for a short period of time (e.g., 3 years) only to implement a unified system shortly after, which could create unnecessary confusion and challenges for consumers and providers. ASHA requests that CMS consider making one transition across post-acute care and refine that payment system over time to ensure it achieves the objectives of improving the quality and efficiency of care for Medicare beneficiaries. This

approach would be an improvement over the current strategy of implementing patient characteristic driven models with significant variation across the different post-acute care venues.

Developing an Accountability Mechanism to Ensure Therapy Services are Delivered

It is ASHA's understanding that if a patient has characteristics that warrant a therapy payment, then the payment will be made even if the home health agency does not provide the medically necessary therapy. In some instances, based on the unique needs of the patient or a refusal of therapy by the patient, therapy may not be provided. However, it is possible that stinting on care could occur in order to maximize reimbursement, which would negatively impact the patient's care. A similar problem was identified with the early version of the Resident-Classification System (RCS) 1, which ultimately became the PDPM for SNFs. ASHA proposed that the PDPM include an accountability mechanism to ensure therapy was delivered when appropriate and payment was made. Ultimately, CMS elected to use an item on the SNF Minimum Data Set (MDS), Section O, for this purpose.

ASHA recommends that CMS include an accountability mechanism for the PDGM to ensure the units of therapy included on claims are monitored closely to identify inappropriate practice patterns by home health agencies. ASHA also requests that CMS create a process that Medicare beneficiaries can raise concerns on access to care or other issues, such as the Medicare ombudsman program, and clarify the oversight responsibilities of Medicare regional offices.

ASHA remains committed to ensuring full access to medically necessary speech-language pathology services under the home health benefit despite the shift to payment based on patient characteristics. Therefore, ASHA recommends that CMS provide educational resources for 1) implementing the PDGM; 2) clarifying the valuable role therapists, including SLPs, play in complying with the home health quality reporting program (HH QRP); 3) reiterating the requirements of the IMPACT Act as well as in the completion of the OASIS in order to ensure all appropriate candidates for therapy services are identified.

Implementing a Split Percentage Payment Approach for a 30-Day Unit of Payment

ASHA appreciates CMS' use of the request for anticipated payment (RAP) to help ensure consolidated billing requirements are enforced. ASHA recognizes consolidated billing as an important tool for program integrity to protect the Medicare trust fund. However, SLPs in private practice have found complying with consolidated billing requirements challenging because existing mechanisms are insufficient. For example, an SLP in private practice will ask the Medicare beneficiary if they are under a home health plan of care and receive health care services in the home. However, most patients are either unaware of consolidated billing requirements or unable (because a cognitive or speech deficit) to inform the private practice SLP that they receive services from a home health agency. The SLP also reviews the Medicare common working file (CWF) to determine if the patient is subject to home health consolidated billing. Unfortunately, the CWF information is often inaccurate due to delays in the availability of data. As a result, SLPs in private practice might provide outpatient services to Medicare beneficiaries without knowing that the patient is under a home health plan of care. Ultimately, the services are denied due to consolidated billing. This is an ongoing issue for outpatient clinicians and there is no mechanism for providing reimbursement to SLPs in private practice even when they have exercised all due diligence.

ASHA understands the use of the RAP, which provides 60% of the episode payment upfront, was intended to incentivize home health agencies to "claim" Medicare beneficiaries in a timely fashion

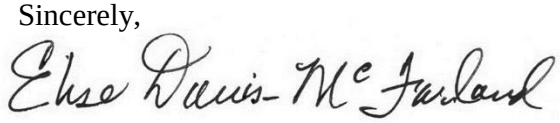
and avoid these unintended consequences. However, ASHA members continue to report that they are denied reimbursement for services rendered due to consolidated billing despite making a good faith effort to confirm the patient was not under a home health plan of care. Transitioning to a 30-day payment episode makes the split percentage process less relevant and ASHA does not have any concerns about CMS' proposal to eliminate it. Although, CMS may find that phasing out the RAP payment is the best approach.

ASHA maintains that the implications of consolidated billing on private practice SLPs still needs to be addressed. In the CY 2018 proposed rule, CMS suggests the use of a Notice of Admission (NOA) to be submitted within five days of admission to the home health episode but the NOA was not finalized. It is ASHA's understanding that a home health NOA would be similar to that used by hospice where NOAs not filed in a timely fashion would result in the hospice agency not being paid for every day the NOA was late. If a similar policy was adopted for home health, ASHA's understanding is that for every day in excess of five days the home health agency failed to file the NOA they would not be paid for those days. This incentivizes home health agencies to "claim" Medicare beneficiaries in a timely fashion, which would help avoid denials for outpatient therapy services provided in good faith.

While CMS has not specifically proposed the use of the NOA in the CY 2019 proposed rule, ASHA encourages CMS to implement the NOA as soon as possible. In addition, ASHA requests CMS to explore its authority to hold home health agencies responsible for any outpatient services delivered to the beneficiary during any period of non-compliance with the NOA requirement by reimbursing SLPs in private practice who may have provided services without knowledge of the home health admission.

Thank you for the opportunity to provide comments on the proposed rule for the home health prospective payment system for CY 2019. If you or your staff have any questions, please contact Sarah Warren, MA, ASHA's director for health care policy for Medicare, at swarren@asha.org.

Sincerely,



Elise Davis-McFarland, PhD, CCC-SLP
2018 ASHA President