AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

March 19, 2018

Michael Plotzke
Abt Associates
4550 Montgomery Avenue #800N
Bethesda, MD 20814

Dear Mr. Plotzke:

On behalf on the American Speech-Language-Hearing Association, I write to you to share additional thoughts on the Home Health Grouping Model (HHGM) for which Abt serves as a contractor to assist the Centers for Medicare & Medicaid Services (CMS) in its development of this payment methodology.

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.

ASHA's members treat Medicare beneficiaries in the home and under home health plans of care; therefore, we have a strong interest in the development and implementation of the HHGM. In February 2018, one of our speech-language pathologist members, Jenny Loehr, served as a representative for ASHA on the technical expert panel (TEP) and provided our initial feedback.

ASHA recognizes the work that Abt and CMS are putting into the development of an alternative payment methodology for the home health setting and understand the significant scope of the undertaking. We appreciate the multiple opportunities provided to assist in the refinement of the model. It is important that the model reflects our members' practice patterns and preserves access to their services for Medicare beneficiaries. We also recognize that the budget legislation signed into law on February 9, 2018, adopted certain elements of the HHGM including the 30-day episode of care and removing the provision of therapy as a determinant for payment. However, there are several elements of the HHGM unaddressed by the recent legislation about which we continue to have concerns. Our comments focus on the follow areas:

1. Implementing a Revised Payment Methodology for Home Health in a Budget Neutral Manner
2. Recognizing that Case Mix Neutral is not the Same as Payment Neutral
3. Developing a Model that Reflects Changes in Practice as We Transition to a Value-Driven Health Care System
4. Providing Payment Based on 30-Day Episodes
5. Identifying Conditions and Comorbidities that Drive Payment
6. Varying Payment Based on Source of Admission
7. Modifying Payment for Non-Routine Supplies

8. Determining Source of Data: Bureau of Labor Statistics or Cost Reports
9. Coordinating the Development of a Unified Post-Acute Care Prospective Payment System
10. Considering Pilot Testing Before Implementation

Implementing a Revised Payment Methodology for Home Health in a Budget Neutral Manner

The budget law signed by President Trump requires the revised payment system for home health to be implemented in a budget neutral manner. ASHA agrees with the Congressional intent behind this provision. As noted in the proposed rule for HHGM in 2017, by implementing it in a non-budget neutral manner, payments to this sector would be reduced by nearly $1 billion in the first year alone. Such a significant reduction would be damaging to beneficiary access to home health care.

While this issue is resolved per federal law, we must reiterate our position that significant revisions to payment systems developed by CMS must always be considered in a budget neutral manner to preserve access to services for Medicare beneficiaries.

Recognizing that Case Mix Neutral is not the Same as Payment Neutral

During the TEP discussion on the revised case mix groupings and weights, Abt representatives stressed numerous times the intent to develop case mix changes that are neutral. In other words, developing case mix weights that would keep the "size of the pie" the same but redistribute the value of the groupings. While technically Abt is not making judgements or recommendations about payment, modifying the value of the case mix groupings payment is being altered. It is critical to ensure that as case mix is revalued, the financial implications are considered to ensure that inappropriate payment incentives do not occur.

Developing a Model that Reflects Changes in Practice as We Transition to a Value-Driven Health Care System

As noted by several TEP representatives, our health care system is changing dramatically with a focus on avoiding hospitalizations and rehospitalizations and delivering care in the setting desired by the patient, often his or her home or place of residence. Given this focus, it seems counterproductive to devalue admissions to home health from the community as these admissions might help prevent hospitalizations. As medical science evolves, patients who previously required institutionalization, such as those receiving a joint replacement, are now often transferred home on the same day as the procedure. Because patients with "minor" surgeries or other procedures are being sent home on the same day, and do not have a prior hospitalization, this further demonstrates that modifying payment based on source of admission to home health runs counter to current practice patterns.

Providing Payment Based on 30-Day Episodes

Upon review of the data presented at the TEP, we noticed that some services, such as physical therapy services, are often provided heavily within the first 30 days and then reduce in frequency or intensity in the later 30 days of the 60-day episode. However, speech-language pathology services are delivered consistently over the 60 days. Given that the provisions of speech-language pathology services remain consistent over 60 days, ASHA is concerned about

"dividing" the payment differently between the first 30-day and second 30-day episode. Additionally, ASHA is concerned that if there is a front-loaded payment for the first 30 days (e.g., 70%) and lower payment for the next 30 days that disincentives service delivery in the second 30-day period and disproportionately impacts Medicare beneficiaries needing speech-language pathology services.

ASHA requests that payment should be provided consistently over each 30-day episode (e.g., 50/50) to avoid stinting on care or discriminating against those with a clinical need for more consistent service delivery across the full episodes of care.

Identifying Conditions and Comorbidities that Drive Payment

As currently structured, the conditions and comorbidities that Abt has selected for payment purposes do not adequately reflect the role speech-language pathologists (SLPs) have in treating patients in the various categories. For example, two clinical categories described in Exhibit 6-1, musculoskeletal rehabilitation and neuro/stroke rehabilitation include speech-language pathology. However, SLPs play a role in several of the other clinical categories within the HHGM including complex nursing interventions, behavioral health care, and medication management teaching and assessment (MMTA).

For example, ASHA's members play a role in the complex nursing interventions category services associated with enteral nutrition and ventilators are included. For this service category, SLPs are often involved in assisting in the development or modification of diet regimens to address issues swallowing liquids and/or foods. Additionally, SLPs work with the health care team to assist in weaning patients from ventilators to avoid the development of pneumonia and/or other complications.

The behavioral health care category also applies to speech-language pathology services for patients with dementia or similar conditions. Finally, SLPs often assist is the identification of cognitive deficits that could impact a patient's ability to manage their medications as outlined in the MMTA category.

SLPs are qualified to identify and treat many conditions as outlined in Exhibit 6-2 including infectious and parasitic diseases; neoplasms; endocrine, nutritional, and metabolic diseases; immunity disorders; diseases of the blood and blood-forming organs; mental, behavioral and neurodevelopmental disorders; diseases of the nervous system and sense organs; diseases of the circulatory system; diseases of the respiratory system; diseases of the digestive system; diseases of the musculoskeletal system and connective tissue; congenital anomalies; symptoms, signs, and ill-defined conditions; and injury and poisoning. SLPs would not be treating the medical condition, such as the stroke, but the consequences or symptoms of the illness or injury such as an inability to speak or swallow.

In terms of the comorbidities that impact payment, ASHA is engaged in the treatment of the conditions listed on pages 82 and 83 of the technical report with the exception of skin diseases. Therefore, we seek to ensure that the comorbidity adjustments are appropriately applied to speech-language pathology services for home health patients.

The functional limitations or impairments that Abt has incorporated into the HHGM are confusing. Specifically, for OASIS items M1220 and M1230 (Understanding of verbal content, speech and oral), Abt states in the technical report that the questions were, "unclear for the purposes of assigning payment." Additionally, Abt notes in the report that OASIS items M1700-M1750, associated with cognition, and M1800-M1890, associated with function, were, "removed due to a negative relationship with resource use." However, further down in Chapter 7 of the report, it appears many of these items were included. ASHA requests that Abt clarify the status of these items as components of HHGM and, if they were in fact excluded, we believe Abt should reconsider and include these items.

It is important to capture these items to sufficiently demonstrate why a patient with significant cognitive or functional impairment might appear to have lower resource use. For example, the intensity of therapy provided might be lower but that services (e.g., nursing) might be higher. It is not necessarily cheaper or less resource intensive to treat clinically complex cases. In addition, not including these items for payment disincentivizes providers from providing the full range of services needed to address related impairments that impact function and outcomes.

ASHA also maintains that items M1800-1890, addressing feeding and home management from the OASIS, should be added to ensure a more accurate picture of patient's clinical complexity.

The practical implications of modifying the existing condition and comorbidity categories to incorporate speech-language pathology services may lead to more appropriate payments to home health agencies under the HHGM, which would ensure reimbursement is adequate and avoid stinting on care. We would be happy to discuss this in further detail with Abt to make sure we are thoroughly understanding the methodology.

Varying Payment Based on Source of Admission
ASHA opposes varying payment based on source of admission; community or institution (e.g., acute care hospital). We believe it is not consistent with changes in practice patterns as we move to a value-driven health care system, as described in more detail above. Additionally, providing a lower payment for community admissions would disincentivize providers from admitting patients from the community, and such a practice would be discriminatory. We would not recommend Abt move forward with a payment differential based on admission source.

Modifying Payment for Non-Routine Supplies
At this time, we do not see a need to address the issue of non-routine supplies in a revised payment system.

Determining Source of Data: Bureau of Labor Statistics or Cost Reports
A hot topic of discussion at the February TEP 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 as there is no mechanism to ensure it is completed uniformly (e.g. a manual or standardized process across the industry) or audited for accuracy. While one TEP representative raised similar concerns about BLS data, without a standardized process cost report data is a poor source of information upon which to base payment. For example, nurse administrators might be included in the cost reporting category for administration costs or nursing costs, potentially

creating inaccurate perceptions about the true cost of nursing services. As a result, we would encourage CMS to consider standardizing the process of cost reporting first and then moving to cost reports at a later date when sufficient and accurate information is available.

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

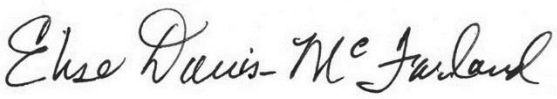
As Abt and CMS are well aware, there is tremendous interest in moving to a unified post-acute care payment system. We remain concerned that the metrics in the current home health prospective payment system, items being collected as required by the Improving Post-Acute Care Transformation (IMPACT) Act, and those collected under the HHGM system are duplicative and burdensome by requiring the same exact information twice or in slightly different ways. Additionally, a change as substantial as the HHGM or a unified payment system requires time (e.g., modifying electronic billing and documentation software) and provider education. ASHA is concerned that CMS might transition to the HHGM for a short period of time (e.g., 3 years) only to implement a unified system shortly after, creating unnecessary confusion and challenges for consumers and providers. CMS should 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.

Considering Pilot Testing Before Implementation

The changes recommended under the HHGM are significant and should not be implemented without appropriate pilot testing.

Thank you in advance for consideration of our feedback. ASHA welcomes an opportunity to discuss our recommendations in more detail with you in person at your earliest convenience. To schedule a meeting or for additional information, please contact Sarah Warren, MA, Director, health care policy, Medicare, at swarren@asha.org.

Sincerely,



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