AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

June 21, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1351-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1351-P; Comments on Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (*Federal Register,* May 6, 2011)

Dear Dr. Berwick:

The American Speech-Language-Hearing Association (ASHA) is the professional, scientific, and credentialing association for 145,000 members and affiliates who are audiologists, speech-language pathologists, and speech, language, and hearing scientists. We appreciate the opportunity to comment on the skilled nursing facility (SNF) prospective payment system (PPS) proposed rule for FY 2012. We are commenting on three issues in the proposed rule: 1) supervision of therapy students, 2) group therapy services, and 3) End of Therapy Other Medicare-Required Assessments.

Therapy Student Supervision

ASHA appreciates the proposed independence of a SNF to determine the type of supervision required of therapy students serving Part A residents. However, ASHA, in consultation with other rehabilitation professionals, has determined that the following basic guidance should be published by the Centers for Medicare & Medicaid Services (CMS) for supervisors:

- Graduate students who have been approved by the supervising speech-language pathologist to practice independently in selected patient situations can perform the selected clinical services without line-of-sight supervision by the supervising speech-language pathologist. The supervising speech-language pathologist must be physically present in the facility and immediately available to provide observation, guidance, and feedback as needed when the student is providing services.
- The supervising speech-language pathologist determines the appropriate amount of supervision based on the graduate student's level of knowledge, experience, and competence.
- When the supervising speech-language pathologist has cleared the graduate student to perform medically necessary patient services and the student provides the appropriate level of services, the services will be counted on the Minimum Data Set (MDS) as skilled therapy minutes.

- The supervising speech-language pathologist is required to review and co-sign all graduate students' patient documentation for all levels of clinical experience and retains full responsibility for the care of the patient.
- Supervising speech-language pathologists are required to have one year of practice experience.
- Graduate students who have not been approved by the supervising speech-language pathologist to practice independently require line-of-sight supervision by the qualified speech-language pathologist during all services. In addition, the supervising speech-language pathologist will have direct contact with the patient during each visit. The graduate student services will be counted on the MDS as skilled therapy minutes.

Student therapy minutes have been considered reimbursable since the inception of the PPS program. To inhibit any aspect of the SNF experience would present a barrier to established advanced graduate student placements. It is important for students to have experience in SNFs to develop their competence in treating this complex population and to increase the probability that they will seek and accept permanent positions in this setting after graduation. We welcome the opportunity to work with CMS if refinement of the above guidelines is necessary.

Group Therapy and Therapy Documentation

CMS' proposal to define group treatment as requiring four persons is not supported by clinical or research evidence. CMS staff has implied that, upon implementation of this rule, group treatment can occur with less than four patients; however, the SNF will be penalized because the session minutes will always be divided by four for MDS purposes. If there are less than four patients selected for treatment ASHA believes the proposed rule will also serve as a disincentive to offer group treatment. CMS usually supports the development of treatment plans that are individualized to the needs of each beneficiary. In this case, though, establishing a standard group size of four suggests that individualized needs are no longer relevant although no published evidence-based research supports the claim that four persons is the optimal group size.

There is no research comparing the size of groups to support the assumption that four persons is the optimal size. Although the literature on group treatment in rehabilitation is not extensive, published studies demonstrate that clinically appropriate patients benefit from group treatment but that the specific number of participants in the group was not prescribed. Attachment A lists 16 articles on group therapy across therapy disciplines. Several articles show that groups of two or three participants are effective. For example, Wertz, et al (1981) studied therapy with three to seven patients with aphasia in groups. There was no research found that suggests that four patients is the optimum number of participants.

ASHA conducted a comprehensive survey of speech-language pathologists in late 2010 to determine the average number of participants in group therapy for speech-language diagnoses. In health care settings, those who see groups treat two or three patients in a group 75.8 percent of the time. In SNFs, the percentage is almost identical (76.1 percent). This result demonstrates that speech-language pathologists typically provide group therapy with less than four patients.

The following is a simple yet clear illustration of how a speech-language disorder can benefit from group therapy whether there are two, three, or four participants. A patient with aphasia needs to interact with another patient in order to generalize the skills learned during individual treatment to a more functional communication situation. A group of two persons also allows the patient to work on elements of communication that are impossible in individual treatment. In the current proposal, if two other patients are not available for this group, facility management may discourage the group treatment session because of the arithmetic penalty to the number of minutes recorded for Resource Utilization Group (RUG) purposes.

The CMS proposed rule discounts the professional judgment of speech-language pathologists in their own determination of appropriate group size for each beneficiary. In speech-language pathology treatment there is a natural clinical progression of group size because severe stroke and head trauma patients cannot function well in large groups (e.g., four) in the early stage of rehabilitation. Smaller group size (e.g., two or three) is optimal at this time.

In summary, there is no clinical or research basis for this type of group size restriction. CMS is, in effect, rendering a treatment decision without evidence that such a decision is therapeutic. ASHA recommends that the group treatment policy for Part A patients continue as has been in effect since 1998: two to four participants with a maximum of 25 percent of treatment in group mode, per discipline, per week. We do not contest the related CMS proposal to allocate RUG minutes among the participants.

End of Therapy Other Medicare-Required Assessments (EOT OMRAs)
We understand that whether the facility has a five-day or seven-day therapy schedule, the proposal will require that a patient be discharged from therapy and a new assessment performed if the patient has not received any therapy services for three consecutive days. This applies to residents who are currently assigned to a therapy RUG-IV group. We believe such a rule forces therapists to perform unnecessary discharge and assessment services that do not contribute in any way to the functional progress of the resident. There are many reasons why a resident could miss a Friday treatment (e.g., resident illness, therapist illness, patient refusal, visit to doctor's office) that have nothing to do with a need for reassessment, yet in a five-day therapy facility this would result in three days without therapy. We recommend that the EOT OMRA requirement be revised to four days in order to avoid many of the unnecessary discharges and reassessments.

Thank you for the opportunity to present our concerns regarding SNF PPS. Should you need further information, please contact Mark Kander, ASHA's director of health care regulatory analysis, at 301-296-5669 or mkander@asha.org.

Sincerely,

Paul R. Rao, PhD, CCC, CPHQ, FACHE
2011 ASHA President

Attachment A

Selected Research on Group Therapy

None suggest that four patients is the optimum number of patients for a group.

Brogardh, C., & Sjolund, B. H. (2006). Constraint-induced movement therapy in patients with stroke: A pilot study on effects of small group training and of extended mitt use. *Clinical Rehabilitation, 20*(3), 218-227.

Coulter, C. L., M, W. J., & M, S. J. (2009). Group physiotherapy provides similar outcomes for participants after joint replacement surgery as 1-to-1 physiotherapy: A sequential cohort study. *Archives of Physical Medicine & Rehabilitation, 90*(10), 1727-1733.

De Weerdt, W. G., Nuyens, G., Feys, H., Vangronsveld, P., Van de Winckel, A., Nieuwboer, A., et al. (2001). Group physiotherapy improves time use by patients with stroke in rehabilitation. *Australian Journal of Physiotherapy, 47*(1), 53-61.

Demain, S., Smith, J. F., & Hiller, L. (2001). Comparison of group and individual physiotherapy for female urinary incontinence. *Physiotherapy, 87*(5), 235-242.

Dobrez, D. G., Lo Sasso, A. T., & Heinemann, A. W. (2004). The effect of prospective payment on rehabilitative care. *Archives of Physical Medicine & Rehabilitation, 85*(12), 1909-1914.

Gold, D. T., Shipp, K. M., Pieper, C. F., Purser, J. L., Duncan, P. W., Martinez, S., et al. (2004). Group treatment improves trunk strength and psychological status in older women with vertebral fractures: Results of a randomized clinical trial. *Journal of the American Geriatrics Society, 52*(9), 1471-1478.

Graham, M. S., & Avent, J. (2004). A discipline-wide approach to group treatment. *Topics in Language Disorders, 24*(2), 105.

Leung, D. P., Ng, A. K., & Fong, K. N. (2009). Effect of small group treatment of the modified constraint induced movement therapy for clients with chronic stroke in a community setting. *Human Movement Science, 28*(6), 798-808.

Mannerkorpi, K., & Gard, G. (2003). Physiotherapy group treatment for patients with fibromyalgia - an embodied learning process. *Disability and Rehabilitation, 25*(24), 1372-1380.

Molinari, V. (2003). Group therapy in long term care sites. *Clinical Gerontologist, 25*(1/2), 13-24.

Onsworth, T., Fleming, J., Shum, D., Kuipers, P., & Strong, J. (2008). Comparison of individual, group and combined intervention formats in a randomized controlled trial for facilitating

goal attainment and improving psychosocial function following acquired brain injury. *Journal of Rehabilitation Medicine, 40*(2), 81-88.

Spilak, C. L. (1999). Incorporating occupational therapy group treatment in long-term care. *Topics in Geriatric Rehabilitation, 15*(2), 48-55.

Tamir, R., Dickstein, R., & Huberman, M. (2007). Integration of motor imagery and physical practice in group treatment applied to subjects with Parkinson's disease. *Neurorehabilitation and Neural Repair, 21*(1), 58-75.

Thompson, R., & McKinstry, W. (2009). How do rehabilitation patients spend their days? An investigation into the effect of a group therapy programme on time use. *New Zealand Journal of Physiotherapy, 37*(3), 122-126.

Wertz, R. T., Collins, M. J., Weiss, D., Kurtzke, J. F., Friden, T., Brookshire, R. H., et al. (1981). Veterans Administration cooperative study on aphasia: A comparison of individual and group treatment. *Journal of Speech and Hearing Research, 24*(4), 580-594.