



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

September 13, 2010

Submitted electronically: www.regulations.gov

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1510-P
Baltimore, Maryland 21244-1850

Re: [CMS-1510-P] Medicare Program; Home Health Prospective Payment System Rate Update for CY 2011

Dear Dr. Berwick:

The American Speech-Language-Hearing Association (ASHA) is the professional and scientific association representing 140,000 speech-language pathologists, audiologists, and speech-language and hearing scientists. We appreciate the opportunity to comment on the proposed revisions to the home health prospective payment system for calendar year (CY) 2011.

Home Health Care Quality Improvement (p. 43250)

Of the twelve current outcome measures that are posted in *Home Health Compare*, none address communication or swallowing capabilities (www.medicare.gov/HHCompare/Home.asp). The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, required in CY 2012, will provide minimal information regarding communication or swallowing. The proposed regulations are designed to curb overutilization—but we do not see discussion regarding CMS efforts to prevent underutilization. ASHA has received reports from speech-language pathologists (SLPs) contracted by home health agencies (HHAs) regarding the failure to authorize needed SLP services. A recent statement from an SLP in Colorado is typical of complaints we have received:

When the HHA does not have an SLP that is qualified to provide augmentative & alternative communication (AAC) services, for example, it does not provide the services at all nor does it contract out to do so. The patient simply goes without services in home health until the 60-day episode ends.

Another underutilization scenario reported is when there have been enough occupational and/or physical therapy visits to elevate the beneficiary to a new therapy payment tier. The HHA does not approve additional SLP visits because there is no financial incentive.

A third circumstance reported to ASHA creates underutilization and occurs when a videofluoroscopic swallowing assessment is required at a hospital. Some HHAs refuse to follow the SLP's recommendation for the referral in order to avoid the cost of the speech-language pathologist incurred by the hospital.

Therapy Coverage Requirements (p. 43245)

We are supportive of the proposed additional requirements for documentation of the patient's clinical record, including: therapy treatment goals to be described in the plan of care; objective measurement obtained during the functional assessment; objective evidence or a clinical supportable statement of expectation that the patient's condition has the potential to improve; and clarification that "material" improvement means that the patient is making functional improvements that are ongoing and of practical value. The elements of documentation added in the proposed regulation are reflective of professional standards for the practice of speech-language pathology.

Functional Reassessment on 13th and 19th Therapy Visits (p. 43246)

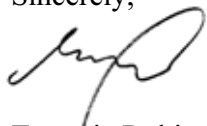
At section 409.44(c)(2)(i)(B), the regulation is unclear how the patient will be "functionally reassessed by a qualified therapist on the 13th and 19th therapy visits and at least every 30 days." The following concerns apply if the 13th and 19th visit is in regard to total visits for all disciplines.

- It is clinically inappropriate for one discipline to perform a reassessment for another discipline and would be constitute practicing outside one's scope of practice according to most state licensure boards.
- Progress or lack of progress in one discipline cannot be assumed to apply to other disciplines. A patient could be making measurable progress toward goals in speech-language pathology but not in physical therapy. Thus, the functional progress indicated by the reassessment conducted on the 13th visit could vary significantly depending upon which therapy discipline conducted the reassessment.
- At the 13th visit, if a patient has received occupational therapy, physical therapy, and speech-language pathology services, each discipline will have provided only a limited number of treatment sessions. Performing a reassessment in one or all three disciplines after such a short treatment interval is not an effective use of that treatment visit.

Because of the legal and clinical concerns presented in the above paragraph, ASHA recommends that 409.44(c)(2)(i)(B) be clarified by adding "per discipline" after "at least every 30 days." For Part B therapy services, the maximum interval for progress reports is 30 calendar days (*Benefit Policy Manual*, Chapter 15, section 220.3.D). We recommend that the same time period be adopted for therapy services in HHAs with the requirement of a formal reassessment by each discipline that has evaluated/treated the patient during a 30-day period. A 30-day requirement will often result in a shorter interval than the 13-day rule would have yielded. We do not believe that there would be a significantly improved capability to detect unnecessary care by adopting the 13 and 19 visit interval as opposed to only a 30-day interval. We also believe that the 30-day period will be much easier for the therapists to schedule and track. We recommend that the 30-day period include a ± 5 -day latitude in order to avoid inefficiencies in scheduling visits.

For additional information or clarification, please contact Mark Kander at 301-296-5669 or mkander@asha.org.

Sincerely,



Tommie Robinson
2010 ASHA President