



June 7, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1746-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments on the fiscal year (FY) 2022 skilled nursing facility (SNF) prospective payment system (PPS) proposed rule. ASHA members, particularly speech-language pathologists (SLPs), provide critical health care services to patients in SNFs and will be significantly impacted by the proposed rule. ASHA is concerned about the impact of the parity adjustment on access to medically necessary care, as well as our members' ability to use their clinical judgment to treat SNF residents.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 218,000 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 more than 12,000 SLPs work in SNFs.<sup>1</sup>

### **Section V.C.2. FY 2020 Changes in SNF Case-Mix Utilization**

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) released critical therapy service delivery data from the early months of the Patient Driven Payment Model (PDPM) and the Coronavirus Disease 2019 (COVID-19) pandemic. Due in large part to this data, CMS has proposed a 5% parity adjustment and seeks comments on how to implement the adjustment.

ASHA remains concerned that administrative mandates—not patient needs or clinical judgment—primarily continue to drive care delivery decisions. Due to the industry response in implementing PDPM, a 5% reduction could have an adverse impact on patients and clinicians in SNFs rather than effectively ensuring compliance with regulatory requirements. ASHA urges CMS to consider the full range of factors that may have contributed to the SNF industry's departure from its budget neutrality expectations and identify ways in which the parity adjustment may be refined, targeted to SNFs that have violated the payment system's regulatory requirements, and mitigated to ensure patient access to clinically indicated and appropriate therapy services.

In the proposed rule, CMS notes that average therapy minutes provided per patient per day dropped from 91 minutes to 62 minutes, a drop of approximately 30%. The intent of PDPM was to realign the payment system to address instances where excess therapy was provided in order to increase reimbursement. Multiple stakeholders, including ASHA, expected a decrease in the amount of therapy provided based on our members' reports, this decrease is due in part to a reduction in SLPs employed in SNFs including layoffs and a reduction in hours and/or wages.

ASHA began hearing from its membership in the summer of 2019, prior to PDPM implementation, with concerns around the use of predictive analytic tools in electronic health records or other mechanisms to dictate the number of therapy minutes a patient could receive. ASHA often heard that therapy evaluations were arbitrarily limited to 15 or 30 minutes and treatment sessions had similar administrative limitations. Given that accurate identification of patient characteristics—such as diagnosis and comorbidities—determine payment, it is counterintuitive to limit evaluation time. It is critical for SLPs to have sufficient evaluation time in order to accurately and comprehensively assess and thoroughly document the individual patient's needs as well as identify appropriate reimbursement criteria. The arbitrary limitation on the number of minutes a patient may receive runs counter to CMS's expectation that patients receive care based on an individualized plan of care. Such limitations also violate the ethical standards established by ASHA and state licensure boards adhered to by SLPs.<sup>2</sup>

In addition, CMS notes that after the transition to PDPM, the number of stays where a patient received any group and concurrent therapy was 29% and 32% respectively, which is a significant increase from the previous payment system. ASHA maintains that group and concurrent therapy are important methods of service delivery when based on the clinical presentation and needs of the patient. During the transition to PDPM, ASHA was supportive of many of the changes to group and concurrent therapy made over time, including the allowance for flexibility in the size of the group from two to six patients. However, ASHA recognized a mechanism was needed to ensure that patients and therapists were not pressured to use group and concurrent therapy as an inappropriate mechanism to reduce staffing costs. Given historical utilization data, and recognizing the need for additional research and evidence, ASHA supported a limit of 25% per patient per therapy discipline on the use of group and concurrent therapy, combined. CMS declined to impose an enforcement mechanism for the 25% limitation. However, based on the data from the proposed rule, it is clear that a mechanism—such as a financial penalty for exceeding the limitation—is critical. ASHA recommends that CMS consult with stakeholders to determine any future updates to this limitation based on the research and evidence.

CMS also highlights surprising COVID-19 statistics in the proposed rule. For example, only 9.8% of SNF residents had a documented COVID-19 diagnosis and only 15.6% used a public health emergency (PHE) related waiver. Those statistics are striking and require further examination. Based on this data, it might appear that service delivery patterns were minimally impacted by COVID-19 and are largely driven by PDPM implementation. There was likely a higher percentage of COVID-19 patients than the claims data reflect because of the challenges SNFs faced early in the PHE with accessing COVID-19 tests, changes in diagnosis coding recommendations from the Centers for Disease Control and Prevention (CDC) over the course of the PHE, and changes in diagnosis coding. However, ASHA is

concerned that a demonstrated and consistent lack of attention to accurate and comprehensive coding and documentation within the SNF industry, which persisted from the Resource Utilization Group (RUG) system through the implementation of PDPM, may lead to further parity adjustments in the coming years due to the disconnect between identified patient needs and actual service delivery. Specifically, while there is no “immediate” financial incentive to report data, such as a COVID-19 diagnosis on claims and the Minimum Data Set (MDS), the financial incentive to do so resides in more accurate identification of patient needs to avoid future parity adjustments.

ASHA does not believe that the percentage of patients with a COVID-19 diagnosis or waiver utilization statistics alone paint a complete picture of the PHE’s impact on SNFs. To slow the transmission of COVID-19, SLPs and other clinical staff were often unable to access the facility to provide care to patients. Many patients in SNFs required a different constellation of services than the “traditional” patient where therapy may not have been the primary or immediate clinical need. All SNF patients were impacted by COVID-19 pandemic to some extent, whether or not they tested positive for the virus itself. All patients were subject to isolation, often for significant periods of time, and preliminary data is emerging regarding an increase of depression<sup>3</sup>. While CMS data reflects that service delivery began dropping prior to the pandemic, the impact of COVID-19 cannot be discounted.

CMS states in the proposed rule that despite the changes in service delivery patterns (e.g., a reduction in therapy provision and an increase in the use of group and concurrent therapy), quality metrics such as pressure ulcers, hospital readmissions, and falls with major injury did not seem to be adversely impacted. While this is good news, ASHA maintains that these metrics do not provide an accurate or comprehensive picture of the impact of these changes on quality related to therapy services. For example, cognitive function metrics, such as the Brief Interview of Mental Status (BIMS), currently collected on the MDS are not sensitive enough to capture patient characteristics and needs. Discipline-specific metrics are necessary. Better cognitive, communication, and swallowing measures are necessary to accurately capture the impact of service delivery changes related to speech-language pathology services. In addition, given the historical pattern of providing minimal data to achieve maximum reimbursement, ASHA maintains that CMS must implement patient reported outcomes measures (PROMs) as soon as possible to ensure a more comprehensive assessment of quality. ASHA appreciates the consideration of two such PROMs in future years of the SNF value-based purchasing program (VBP) and recommends that CMS build upon this foundation expeditiously.

ASHA recognizes that the data CMS has released is national average data and that not all SNFs responded inappropriately to the PDPM transition. Though CMS data indicate that COVID-19 appears to have had a limited impact, the pandemic took a financial toll on the industry as a whole and a significant toll on those working in this sector who worked long hours while placing themselves and their families at great personal risk for exposure to COVID-19. Although ASHA appreciates the rationale CMS provides for the parity adjustment, ASHA questions whether this is the time to impose such a reduction or if additional time and data could better ensure a more accurate and appropriate parity adjustment in a future year. ASHA recommends that CMS closely consider the parity adjustment’s impact on patients and clinicians working in this setting and identify ways to mitigate that impact and target payment reductions more specifically to effect desired policy and behavioral changes.

During the transition to PDPM, 38% of ASHA members reported that they experienced a reduction in hours or a change in employment status from full-time to part-time.<sup>4</sup> This data indicates that when SNFs are faced with lower reimbursement, many adjust their business model to maintain profit by reducing staff and service provision. A 5% parity reduction could have the same impact as the PDPM transition, and patients and clinicians could be the most adversely impacted.

Given the need to balance fairness in applying a payment reduction and uphold CMS's budget neutrality expectations, ASHA strongly recommends that CMS consider ways to mitigate the impact of a parity adjustment. For example, CMS could apply a penalty to SNFs who exceed the 25% limitation on group and concurrent therapy. These funds could be used to reduce the amount of the parity adjustment for all SNFs while focusing on outliers. CMS could also consider COVID-19's financial impact, including the high cost of personal protective equipment (PPE) and infection control measures used with COVID-19 and non-COVID-19 patients alike. This might also lead CMS to reduce the level of the parity adjustment in recognition of these extensive expenses not incurred in previous years prior to the pandemic.

ASHA maintains that there must be accountability for violating CMS's budget neutrality expectations. ASHA is concerned that delaying it or phasing in the adjustment potentially creates a scenario whereby the 5% reduction proposed in 2022—absent behavioral changes within the industry—is compounded in coming years and creates an unsustainable environment for the post-acute care sector. ASHA offers to work with CMS to identify ways to ensure compliance with the payment system's regulatory requirements for an individualized plan of care and robust coding and documentation to mitigate the need for any future parity adjustments.

In summary, **ASHA does not support implementing the proposed parity adjustment in 2022 and recommends that CMS:**

- 1. identify ways to reduce or mitigate the parity adjustment to target problematic administrative policies and behaviors, such as imposing a financial penalty on SNFs who exceed the 25% limitation on group and concurrent therapy sessions,**
- 2. allow time for additional data collection to demonstrate exactly what impact PDPM has had without the confounding variable of the acute response to the COVID-19 pandemic seen throughout most of 2020, and**
- 3. recognize the major financial and workforce impact COVID-19 had on the industry overall and allow some time for recovery from these impacts.**

**ASHA asks for CMS to revisit the parity adjustment proposal in the 2023 rulemaking cycle.**

### **Section V.C.3. Methodology for Recalibrating the PDPM Parity Adjustment**

Based on the data in the proposed rule, it is clear there was a higher than anticipated increase in speech-language pathology case mix and corresponding utilization. For example, in Table 23 of the rule, CMS estimated that the speech-language pathology case

mix would be 1.39 but the actual case mix (when accounting for COVID-19) was 1.67. Physical and occupational therapy did not experience such a significant difference from the estimated to actual case mix data.

This might seem like a problematic trend, but there are several contributing factors that explain the departure from CMS's estimates. First, physical and occupational therapy metrics, found in Section GG of the MDS, have had a direct impact on the SNF's reimbursement associated with the Quality Reporting Program (QRP) for several years. SNFs needed to ensure that physical and occupational coding was accurate to avoid a 2% reduction in payment. Speech-language pathology services have not had this financial incentive to ensure comprehensive and accurate coding until PDPM.

Second, the data analysis undertaken as part of the development process—including the work of the technical expert panel—recognized a direct link between resource use and cost for speech-language pathology services. This is particularly true for the comorbidities that are recognized as part of the speech-language pathology case mix and the exemption from the variable per diem payment applied to physical and occupational therapy services. SNFs were appropriately incentivized to ensure speech-language pathology services, and associated diagnosis coding, were comprehensive and accurate for the first time because the link between resource use and cost was recognized for the first time.

ASHA engaged in a member education campaign to prepare our members for the PDPM transition and major components of this campaign were designed to dispel the myths around administrative mandates imposed by employers and reinforce the value of comprehensive and accurate coding. SLPs heard their charge and responded by engaging in multidisciplinary care teams and participating in the completion of the MDS and claims. This is a trend to be valued because it better reflects the care needs of patients and builds a more robust data repository on which to improve PDPM over time.

### **Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs—Request for Information (RFI)**

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ASHA thanks CMS for actively seeking to ensure that Medicare providers address health equity to improve the quality and outcomes of care for their patients. ASHA members are committed to improving health equity. Many of the post-acute care assessment tools, such as the MDS, capture data that providers and CMS can use to reduce health disparities in the areas of race, ethnicity, transportation, gender, and language access (e.g., interpreter, translated materials). However, ASHA recommends that CMS collect additional forms of standardized patient assessment data (SPADEs), and act on the information obtained from the data collection to improve health outcomes. Providers must do more than report this data. For example, the data can be stratified by medically underrepresented groups to determine their experience and if disparities exist then providers can implement strategies focused on improved outcomes of care and develop quality measures to address identified inequities.

ASHA recommends that providers collect standardized data associated with the following:

- **Ability to communicate:** An inability to communicate because of hearing loss, a cognitive or speech impairment, articulation, and/or inability to comprehend clinical

instructions impact a patient's overall ability to participate in the care planning process and benefit from skilled interventions. Effective communication represents the core and foundation of patient-centered care and without it, patients will be less satisfied, less enabled, and may demonstrate more symptoms, higher rates of readmission, and greater use of resources.

- **Insurance coverage (including lack thereof):** Health insurance coverage has been identified as a key social determinant of health domain and is one of the largest barriers to health care access.<sup>5</sup> Lack of health insurance contributes to health disparities. For example, patients who are underinsured or uninsured may forgo or delay necessary care, which impacts the quality and outcomes of care they receive.
- **Access to technology (e.g., broadband internet access or tablets):** Patients without access to technology and digital literacy may not be able to receive timely and clinically appropriate care via telehealth; thereby, delaying care and adversely impacting outcomes and quality of care.
- **Forms of economic insecurity such as, but not limited to, housing or food insecurity:** Patients with one or more forms of economic insecurity may have to choose between medical care and responding to other financial demands. The stress of such choices adversely impacts the overall physical and mental health of the individual. When forced to choose, medical care may be a lower immediate priority despite the significant financial impact delaying care can have on an individual's overall economic security.
- **Availability of caregiver support.** Lack of caregiver support creates access challenges that may reinforce health disparities.
- **Health literacy:** The patient's ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment needs to be assessed.<sup>6</sup> Health literacy is not restricted to only a person's ability to read and write. If a person also has a communication disorder, it can increase their difficulties with processing and using health information. Other factors that play a role in how well someone understands health information that they receive through hearing, seeing, and reading include:
  - experience with the health care system,
  - cultural and linguistic factors,
  - the format of materials, and
  - how information is communicated.

As CMS collects additional health equity SPADEs and develops longitudinal data associated with their impact on quality and outcomes, ASHA recommends sharing this information with providers via a mechanism such as confidential feedback reports to help further the goal of health equity. But data sharing is not enough. Providers in many settings, particularly post-acute care settings, have access to some of this data now; however, it is unclear if they use it in any meaningful way to improve the quality of care for the patients they treat.

ASHA recommends that CMS identify how to hold providers accountable for utilizing the health equity data to improve care for their patients through corrective action plans or other

means. For example, as CMS moves from reporting to performance on quality and health equity metrics, it could apply a payment penalty to providers who do not use health equity data to effectively improve care for their patient populations or apply a bonus for those who do so systematically.


ASHA also recommends that CMS identify strategies for mitigating misrepresentation of quality and outcomes data to ensure such data are taken in context with health equity factors. In some cases, providers may misrepresent or misunderstand the data in the absence of the important context health equity metrics provide. For example, a hospital could present superior quality metrics in a particular geographic region as compared to its competitors. But, if this hospital had a patient population not adversely impacted by factors such as economic insecurity or language or communication barriers as compared to those same competitors, it would be an inappropriate comparison. ASHA recommends comparing outcomes with respect to similar patient populations or risk adjusted accordingly.

## Conclusion

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Thank you for your consideration of ASHA's comments. If you or your staff have any questions, please contact Sarah Warren, ASHA's director for health care policy for Medicare, at [swarren@asha.org](mailto:swarren@asha.org).

Sincerely,



A. Lynn Williams, PhD, CCC-SLP  
2021 ASHA President

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<sup>1</sup> American Speech-Language-Hearing Association. (2020). *2019 Benefits and Programs Survey*. <https://www.asha.org/siteassets/surveys/2019-benefits-and-programs-survey-ccc-slp.pdf>.

<sup>2</sup> American Speech-Language-Hearing Association Code of Ethics. <https://www.asha.org/code-of-ethics/>

<sup>3</sup> Agronin, Marc. "The Impact of COVID-19 on Mental Health in Long-Term Care Settings." November 11, 2020. <https://www.psychiatrictimes.com/view/the-impact-of-covid-19-on-mental-health-in-long-term-care-settings>

<sup>4</sup> American Speech-Language-Hearing Association. (2020). *ASHA Members Report Their PDPM Experiences*. <https://leader.pubs.asha.org/doi/10.1044/leader.OTP.25042020.40>.

<sup>5</sup> Healthy People.gov. (n.d.). *Access to Health Services*. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health#3>.

<sup>6</sup> American Speech-Language-Hearing Association. (n.d.). *Health Literacy*. <https://www.asha.org/slp/healthliteracy/>.