



June 5, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Attention: CMS–1779–P
P.O. Box 8016
Baltimore, MD 21244–8016

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 2024

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the skilled nursing facility (SNF) related provisions within the above referenced proposed rule and requests for information.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Many ASHA speech-language pathology members work in SNFs and, as a result, have a vested interest in ensuring the regulatory and payment policies are appropriate to ensure Medicare beneficiary access to this critical level of care.

V. A. Technical Updates to PDPM ICD-10 Mappings

The Centers for Medicare & Medicaid Services (CMS) requests information on updates to the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM, hereafter referred to as ICD-10) code mappings that assign patients to the patient driven payment model (PDPM) clinical categories, such as the speech-language pathology component. ASHA is committed to ensuring that the speech-language pathology component of PDPM is accurate and comprehensive to ensure it appropriately recognizes the needs of SNF residents.

Since implementation of PDPM, the COVID-19 pandemic has transformed the needs of SNF residents, and the way care is delivered. One challenge many long COVID patients and other SNF residents experience is the impact on respiration, which is captured in section I8000 of the minimum data set (MDS) by ICD-10 codes J00-J06. Speech-language pathologists (SLPs) play a critical role on care teams where they are treating some of the consequences associated with respiratory challenges, regardless of the underlying etiology, as described in greater detail below.¹ **Therefore, ASHA recommends the J00-J06 ICD-10 codes be added to the speech-language pathology component of the PDPM payment methodology.**

A patient's respiration can be impacted by long COVID in a variety of ways—including damage to the lungs by the disease or the impact of mechanical ventilation—if it was acquired during the acute phase of illness.^{2,3,4,5,6} Respiration impacts a person's ability to communicate, particularly

as it relates to voice and the ability to swallow safely.⁷ A swallowing disorder, or dysphagia, is a leading cause of malnutrition, dehydration, aspiration pneumonia, and rehospitalization in the population who receives care in SNFs, and leads to increased lengths of stay in acute and post-acute care settings.

In individuals with respiratory compromise, SLPs assess the person's ability and efficiency in communication and swallowing. SLPs may target a variety of impairments that impact functional communication and swallowing. Some examples of these treatments include breath support for speech impacting the loudness or quality of voice in spoken communication, and respiratory-swallowing coordination to impact laryngeal closure and related swallowing safety.⁸ It is critical to capture this diagnostic information via claims and the MDS, reinforce the role of SLPs in treating these patients, and recognize the resource use and cost associated with addressing these impairments. **ASHA reiterates its recommendation to capture this information for the purposes of the speech-language pathology payment under PDPM.**

VI. C. SNF QRP Quality Measures Proposals

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) Measure

On May 1, 2023, the White House announced that COVID-19 vaccine requirements for federal employees, federal contractors, and international air travelers will end on May 11, the same day the federal public health emergency ends. In addition, the Departments of Health and Human Services (HHS) and Homeland Security (DHS) announced they will begin the process of ending their vaccine requirements for Head Start educators, health care facilities certified by CMS, and certain noncitizens at the United States' land border. **ASHA requests that CMS clarify whether the elimination of a vaccine "mandate" will impact the adoption or use of the proposed COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure.**

Discharge Function Score (DC Function) Measure

ASHA agrees that determining if improvement or maintenance of function has occurred upon discharge from a post-acute episode of care; then, it is critical to ensure Medicare beneficiaries are receiving quality care and achieving the outcomes they require to move on to the next level of care. To that end, CMS proposes to **add** the *Discharge Function Score* measure and **remove** the *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan)* and the *Application of the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score)* measure and the *Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score)* measure.

While mobility and self-care are essential elements of function, **ASHA reiterates our longstanding concern that Section GG of the MDS and the measures associated with function, which CMS has adopted and proposed to date, are insufficient to capture all associated functional domains, including communication and cognition.** An incomplete assessment of holistic functions does not adequately capture the outcomes required for safety and independence. **ASHA remains committed to assisting CMS and post-acute care providers, such as SNFs, to address all domains of function.**

VI. D. Principles for Selecting and Prioritizing SNF QRP Quality Measures and Concepts Under Consideration for Future Years: Request for Information (RFI)

CMS includes a request for information on the availability of cognitive function measures outside of the SNF quality reporting program (QRP) that may be available for immediate use or that may be adapted or developed for use in the SNF QRP, using the Brief Interview of Mental Status (BIMS), Confusion Assessment Method (CAM©), PROMIS Cognitive Function short forms, and PROMIS Neuro-QoL, or other instruments. In addition, CMS seeks input on the feasibility of measuring improvement in cognitive function during a SNF stay, which averages approximately 30 days; the cognitive skills (e.g, executive functions) that are more likely to improve during a SNF stay; conditions for which measures of maintenance—rather than improvement in cognitive function—are more practical; and the types of intervention that have been demonstrated to assist in improving or maintaining cognitive function.

ASHA appreciates CMS’s continued commitment to developing assessment tools and quality measures that are reflective of the full range of illnesses and injuries that SNF residents may experience, including those that impact cognition. However, **ASHA has long maintained that the BIMS is insufficient and has encouraged CMS to identify a different way to capture cognitive function.** The primary challenges to adopting a different instrument remain the proprietary nature of many cognitive assessment tools and the length of such tools, which lead to concerns about the administrative burden. Despite these barriers to replacing the BIMS at this time, **ASHA looks forward to continuing to work with CMS to identify a feasible replacement as soon as practicable.**

The BIMS was developed to screen for the presence or absence of a cognitive impairment, not to diagnose or to track changes. It is designed to assess only very basic elements of cognition such as attention, short-term memory, and verbal interaction. As a result, the BIMS is an insufficient method for assessing cognition and does not capture deficits related to executive functioning, judgment, reasoning and other higher level cognitive functions, which are crucial for safety and community reintegration.⁹ The scale is too limited to be used to track changes with sufficient sensitivity and shows low sensitivity in identifying those cognitive deficits impacting community placement.¹⁰ In addition, the constructs being measured by the data elements are not the constructs that are typically the focus of therapy. For example, if short-term memory is impaired, speech-language pathologists (SLPs) will likely determine which compensatory strategies are needed to facilitate the patient’s functioning—given the memory impairment—and train the patient and family members on how to best employ these strategies. One would not expect the patient’s BIMS score to improve with treatment; thus, the BIMS would be a very poor choice of data elements by which to measure outcomes. None of the BIMS data elements should be used to assess the patient’s functional status at any point during the episode of care to determine if there was an improvement in that status.

In addition to the inadequacy of the BIMS, ASHA members report that since the implementation of PDPM, many SNFs are using the BIMS score to inappropriately restrict access to comprehensive cognitive evaluation and patient-centered treatment services. Specifically, ASHA members report that if a SNF resident receives a particular BIMS score (e.g., score >13), their SNF employer tells them that Medicare does not allow the patient to receive cognitive services even if the patient has presented with a cognitive impairment(s) that negatively impacts their safety, ability to participate in treatment, and quality of life. However, BIMS score is not an element of the coverage or payment requirements associated with PDPM. **ASHA strongly recommends that CMS issue guidance that reaffirms that cognitive services are provided**

based on the clinical judgment of the clinician and the clinical presentation of the patient, not the artificial score of a screening tool such as the BIMS.

VII. B. SNF VBP Program Measures

ASHA supports the evolution of the value-based purchasing program (VBP) in SNFs.

Value-based care reaffirms the value of speech-language pathology services while ensuring that patients maintain access to quality care and achieve desired outcomes. ASHA applauds the adoption of the *Discharge to Community (DTC)—Post-Acute Care (PAC) Measure for Skilled Nursing Facilities* (NQF #3481) for the FY 2027 program. Community discharge as a proxy measure for functional independence aims to capture the functional abilities of a patient to perform their activities of daily living and their instrumental activities of daily living, which require critical aspects of communication, including:

- independence in communicating with emergency services;
- expressing wants, needs, and critical medical information;
- safety, such as the ability to eat independently and safely in the community;
- hearing, such as environmental awareness for safety; and
- cognition, including medication management, falls prevention, safety awareness, scheduling, and money management.

Audiologists and SLPs are essential to managing and improving the requisite skills—including hearing, auditory comprehension, language formulation, speech, cognition, and swallowing—to succeed on this discharge to community quality measure.

However, as discussed above, ASHA is concerned with the introduction of the *Discharge Function Score* measure as it is based on section GG of the MDS and focuses almost exclusively on mobility and self-care to the exclusion of functional communication activities.

ASHA reiterates that CMS should consider the full range of discharge metrics that help paint an accurate picture of the quality of and outcomes of care for Medicare beneficiaries.

VII. E. Proposed Changes to the SNF VBP Performance Scoring Methodology

Health Equity Adjustment

ASHA supports the proposed health equity adjustments to SNFs because it allows facilities to demonstrate quality care to all patients, including residents who are dually eligible for Medicare and Medicaid. Economic instability is one of many social determinants of health (SDOH)—or the nonmedical factors such as where people are born, live, learn, work, play, worship, and age—that affect a wide range of health, functioning, and quality-of-life outcomes and risks. In a value-based payment system, identification of and payment adjustment for SDOH are essential because patients with fewer SDOH risk factors become more “attractive” to providers since they will likely have better outcomes and require fewer services and resources as compared to their “riskier” counterparts, despite similar clinical characteristics.

Cherry picking refers to carefully selecting a caseload of the mostly healthy, uncomplicated patients who are the more likely to have good outcomes with the least amount of intervention; thereby, making these patients a “low” financial risk and “high” payment opportunity. Conversely,

lemon dropping occurs when providers are disincentivized from treating patients with one or more SDOH risk factors such as economic instability and lack of access to education and quality health care—including preventative care—leading to chronic conditions, multiple comorbidities, and disabilities in underserved populations. Such patients often require more services, are challenging to manage clinically, require a longer length of stay, and might be more costly. Their risk factors might incorrectly skew a facility's quality scores or measure denominators when these patients are excluded from the measure.

Without health equity payment adjustments, value-based systems inadvertently incentivize *cherry picking* and *lemon dropping*, which leaves the most vulnerable patients without adequate access to care and exacerbating the health disparities common under a fee-for-service payment model.¹¹ ASHA appreciates the health equity adjustment methodology of incentivizing the care of dual eligible patients without penalizing SNFs who are not yet able to meet the 20% threshold during this period.

To ease provider reporting burden, improve patient comfort with questions being asked, and facilitate the highest quality streamlined data collection, **ASHA recommends aligning SDOH data items across all care settings when future health equity quality measures are developed.**

Thank you for considering ASHA's comments. 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 to discuss the cognitive function RFI or the PDPM ICD-10 mappings. Please contact Rebecca Bowen, MS, CCC-SLP, PNAP, ASHA's director for health care policy for value and innovation, with questions regarding quality reporting and value-based purchasing proposals at rbowen@asha.org.

Sincerely,



Robert M. Augustine, PhD, CCC-SLP
2023 ASHA President

¹ Thomas M., McKinley R.K., Freeman, E., Foy, C., Price, D. The Prevalence of Dysfunctional Breathing in Adults in the Community with and Without Asthma. *Prim Care Respir J.* 2005;14(2):78-82.

² Brodsky, M. B., González-Fernández, M., Mendez-Tellez, P. A., Shanholtz, C., Palmer, J. B., & Needham, D. M. (2014). Factors associated with swallowing assessment after oral endotracheal intubation and mechanical ventilation for acute lung injury. *Annals of the American Thoracic Society*, 11(10), 1545-1552.

³ Brodsky, M. B., Huang, M., Shanholtz, C., Mendez-Tellez, P. A., Palmer, J. B., Colantuoni, E., & Needham, D. M. (2017). Recovery from dysphagia symptoms after oral endotracheal intubation in acute respiratory distress syndrome survivors. A 5-year longitudinal study. *Annals of the American Thoracic Society*, 14(3), 376-383.

⁴ Archer, S., Iezzi, C., & Gilpin, L. Swallowing and voice outcomes in patients hospitalised with Covid-19: an observational cohort study. *Archives of Physical Medicine and Rehabilitation* 2021; 102(6), 1084-1090.

⁵ Dawson, C., Capewell, R., Ellis, S., et al. Dysphagia presentation and management following COVID-19: an acute care tertiary centre experience. *Journal of Laryngology and Otology* 2020; <https://doi.org/10.1017/S0022215120002443>.

⁶ Kelly E, Wallace S, Puthicheary Z. Prolonged Intubation and Tracheostomy in COVID-19 Survivors. *ICU Management and Practice* 2020; 20(4).

⁷ Archer, S., Iezzi, C., & Gilpin, L. Swallowing and voice outcomes in patients hospitalised with Covid-19: an observational cohort study. *Archives of Physical Medicine and Rehabilitation* 2021; 102(6),1084-1090.

⁸ American Speech-Language-Hearing Association. (n.d.). *Aerodigestive Disorders*. (Practice Portal). www.asha.org/Practice-Portal/Clinical-Topics/Aerodigestive-Disorders/.

⁹ Marks TS, Giles GM, Al-Heizan MO, Edwards DF. How Well Does the Brief Interview for Mental Status Identify Risk for Cognition Mediated Functional Impairment in a Community Sample? *Arch Rehabil Res Clin Transl*. 2021 Jan 13; 3(1):100102. doi: 10.1016/j.arrct.2021.100102. PMID: 33778475; PMCID: PMC7984985.

¹⁰ Ibid.

¹¹ Navathe, A.S, Liao J.M. Aligning Value-Based Payments With Health Equity: A Framework for Reforming Payment Reforms. *JAMA*. 2022;328(10):925–926. doi:10.1001/jama.2022.14606.