



ASHA
American
Speech-Language-Hearing
Association

August 26, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1747-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-term Care Hospital Quality Reporting Program Requirements

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the calendar year (CY) 2022 home health (HH) prospective payment system (PPS) proposed rule.

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 8,000 members who practice speech-language pathology work in home health.¹

Speech-language pathologists (SLPs) provide critical therapy services to patients in the home. ASHA is concerned about the impact of future budget neutrality payment adjustments on access to medically necessary care, as well as our members' ability to use their clinical judgment to treat home health patients.

ASHA's comments focus on the following sections:

- Section II.B.1. Monitoring the Effects of the Implementation of PDGM
- Section II.B.2. Comment Solicitation on the Annual Determination of the Impact of Differences Between Assumed Behavior Changes and Actual Behavior Changes on Estimated Aggregate Payment Expenditures under the HH PPS
- Section VI. Medicare Provider and Supplier Enrollment Changes
- Section VIII.B. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs – Request for Information

Section II.B.1. Monitoring the Effects of the Implementation of PDGM

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) released critical data on changes in service delivery patterns and Medicare spending following implementation of the Patient-Driven Grouping Model (PDGM) on January 1, 2020. Although it is too soon to determine what impact the Coronavirus Disease 2019 (COVID-19) has had on patients, home health providers (e.g., SLPs), and the payment system overall, the preliminary findings are alarming and correspond with information shared by ASHA members who are working in home health. ASHA recognizes that data are national averages and that not all home health agencies responded inappropriately to the PDGM transition.

CMS states that in 2020 the number of visits provided dropped 12% and that its budget neutrality estimates were exceeded by 6%. It appears that Medicare reimbursements to home health agencies were approximately 34% higher than the cost of delivering care. It is unclear how these service delivery changes will impact the quality and outcomes of care for home health patients because CMS does not release corresponding quality data in the proposed rule. It is also striking that while the clinical complexity of patients—as represented by the level of functional impairment and comorbidities—appears to have increased, the number of visits provided to patients dropped. This seems counterintuitive and must be better understood. ASHA believes several factors explain the increased reporting of functional impairment and comorbidities including, but not limited to, the impact of COVID-19 and the recognition of these factors on reimbursement.

For example, many patients were discharged to home health directly from a hospital rather than receiving care in a skilled nursing facility or other post-acute care setting. These discharges were in part driven by a desire to minimize the risk of contracting COVID-19. These patients were more clinically complex than those patients historically seen in home health. In addition, the previous home health payment system based reimbursement on the number of home health visits provided rather than patient characteristics. PDGM appropriately flipped this reimbursement methodology on its head by reimbursing based on the clinical complexity and needs of the patient for the first time. In other words, home health agencies were reimbursed for accurately and comprehensively recording patient clinical characteristics on the Outcome and Assessment Information Set (OASIS) and claims leading to a higher reporting of functional impairment and comorbidities. However, CMS should continue to monitor this data to determine if the medical record supports the information reported via the OASIS and claims and that therapy services are delivered when clinically indicated for the patient.

ASHA members working in home health report a decrease in service provision. Beginning in 2019, before the implementation of PDGM, many SLPs were laid off or saw a reduction in hours, wages, and/or benefits. ASHA has also experienced a significant increase in member inquiries from SLPs in private practice who are providing services to home health beneficiaries and are unclear how to bill for their services. It is concerning that Medicare home health beneficiaries who need speech-language pathology services are not getting them and are trying to obtain them on an outpatient basis, which is in violation of consolidated billing requirements.

In addition, ASHA members working in home health report that predictive analytic tools, such as electronic health record algorithms, were used to dictate the number and frequency of home health visits despite the clinical needs of the patient and clinical judgment of the SLP. The arbitrary limitation on the number of visits 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.² The data articulated in the proposed rule seem to bolster these member reports and paint a stark picture of the realities on the ground for stakeholders in home health.

CMS has not elected to implement a budget neutrality payment adjustment for 2022 but will continue to monitor the data and may implement an adjustment in the future that could account for multiple years of payments over its budget neutrality expectations. ASHA agrees it is too soon to implement a payment adjustment given the need to recover from the impact of COVID-19 and to allow home health providers an opportunity to continue to learn and adjust for effective PDGM implementation. ASHA also appreciates the need to ensure that home health agencies comply with Medicare regulatory requirements and Medicare budget neutrality expectations. However, given the changes in service delivery that CMS has identified, ASHA is concerned that a budget neutrality payment adjustment may have a negative disproportionate impact on clinicians working in home health and the patients they treat.

If CMS's data are accurate, it may reflect that a portion of the industry responded to changes in the payment system by restricting service delivery. It is possible that a budget neutrality adjustment would stimulate a similar response from the industry. This response would further restrict access to care for Medicare beneficiaries instead of ensuring compliance with Medicare requirements. ASHA urges CMS to consider the full range of factors that may have contributed to the home health industry's departure from its budget neutrality expectations and identify ways in which a payment adjustment may be refined; targeted to home health agencies that have violated the payment system's regulatory requirements; and mitigated to ensure patient access to clinically indicated and appropriate therapy services.

ASHA has identified additional trends from the proposed rule that require further examination. These findings may lead to additional refinements to PDGM and may be used to mitigate the degree of any future budget neutrality adjustment. These trends include the timing of episodes of care (early and late), the source of admission (community or institutional), the level of functional impairment, the comorbidity adjustment, and the number of patients who received little or no therapy.

1. *Timing of Episodes and Source of Admission*

Table 8 of the proposed rule highlights the percentage of patients admitted from the community or an institution as well as the timing of the episode as either early or late. In the development of PDGM, CMS believed it needed to 1) ensure appropriate payment based on actual cost associated with the source of admission and 2) address the significant differential between community and institutional admissions, roughly 75% and 25% respectively. As a result, CMS developed these payment differentials. But it does not seem to have had an impact on the source of admission. ASHA recommends that CMS should determine why there has not been a change in the source of admission, including the impact of COVID in which many patients were not receiving institutional care to mitigate the risk of COVID transmission.

To prevent home health agencies from "cherry picking" patients to maximize profits, it is critical to understand the impact of such payment differentials on agency behavior. ASHA has expressed concern regarding the potential unintended consequence of this policy choice in previous comments. For example, community admissions are "lower-cost" based on historic Medicare data. CMS should determine if some home health agencies are keeping community admissions on for a late episode to maximize reimbursement even when it is not clinically indicated for the patient. On the other hand, because of lower reimbursement for community admissions, CMS should determine if those patients are being "avoided" by some health agencies because they aren't seen as "profitable." Historical Medicare data has shown that institutional admits tend to be "more

costly”; therefore, ASHA recommends that CMS should determine if home health agencies are disproportionately discharging institutional admissions within the first 30 days to control their costs. CMS needs to analyze the data associated with this element of the PDGM reimbursement methodology to ensure patient access to care is not jeopardized.

If such trends are identified, CMS should determine if an enforcement mechanism may be imposed to ensure patients are selected based on need and in compliance with Medicare regulatory requirements (e.g., homebound) rather than the financial benefit associated with a particular patient profile.

2. *Level of Functional Impairment*

PDGM creates a payment differential for each level of functional impairment. This is an important component of the payment system to ensure cost and resource use are appropriately recognized and reimbursed. However, as shown in Table 9 of the proposed rule, the number of patients with a high level of functional impairment exceeded CMS’s estimates by approximately 9%. This may be due to the appropriate financial incentive to reflect this information more accurately. However, if CMS identifies specific home health providers who have indicated a high level of functional impairment simply for the purpose of reimbursement, CMS may target these providers to further refine the level of a budget neutrality payment adjustment in future years.

3. *Comorbidity Adjustment*

ASHA notes that in Table 7 of the proposed rule, the percentage of patients for whom it provided a comorbidity adjustment of low to none was smaller than CMS estimated while the percentage of patients who received a high comorbidity adjustment was higher than CMS estimated. CMS estimated that the percentage of patients who would not trigger a comorbidity adjustment would be 52.0% but, 49.2% had no comorbidity adjustment. Additionally, CMS estimated that only 10.0% of patients would trigger a high comorbidity adjustment but 2020 data showed that 14.0% of patients trigger this adjustment. While the differences in these projections might not be considered “significant,” this requires further examination. It may be that the recognition of comorbidities provided a proper financial incentive for home health agencies to report this data. But ensuring that the medical record supports this in order to refine the potential budget neutrality adjustment is critical to ensure those providers who are not complying with CMS’s expectations bear the burden of a future payment adjustment.

4. *Therapy Provision*

Since CMS first introduced home health payment reform in 2017, ASHA has supported the development of a patient-centered payment model but has had significant concerns that it would inappropriately reduce the delivery of speech-language pathology services. ASHA appreciates the numerous efforts CMS has made to ensure that all stakeholders recognize the critical value of therapy services, including speech-language pathology services. By making statements to this effect in previous rulemaking as well as an MLN Matters article, CMS helps reinforce the value of therapy and the importance of providing all medically necessary services to home health patients.³ ASHA has engaged in a significant member advocacy campaign to educate SLPs who are working in home health of their value, to ensure the needs of their patients are met, and that they are in compliance with Medicare requirements for service delivery.

Despite these efforts, ASHA members have reported that administrative mandates are driving care decisions instead of their patients' needs and their clinical judgement. In some cases, predictive analytic tools are being used to dictate the number and frequency of visits. SLPs are often told that they are not allowed to provide certain types of therapy services (e.g., cognitive therapy) or provide services to patients who do not have a diagnosis that triggers an additional payment. Unfortunately, the data presented in Table 10 and Figure 3 of the proposed rule seem to reinforce ASHA members' experiences. Nearly 43% of home health patients received no therapy, 5% higher than CMS projections. In addition, CMS data shows that more 30-day periods of care received six or fewer therapy visits while the percentage of 30-day periods of care that received seven or more therapy visits dropped. In other words, Medicare beneficiaries received fewer therapy visits than under the previous payment system. ASHA recommends that CMS should determine if limiting the therapy provision to six or fewer visits by a subsection of home health providers has skewed the data in a way that inflates the perceived need for or level of a future budget neutrality adjustment. Perhaps this subsection of providers may assume a larger share of any potential negative payment adjustments.

ASHA strongly recommends that CMS determine if a therapy payment is being triggered through the completion of the OASIS while the therapy provision is inappropriately reduced or may not be provided at all. The home health agencies that consistently receive a therapy payment but fail to provide the appropriate therapy services must be held accountable to maintain access to care and mitigate the impact of a budget neutrality payment adjustment.

Section II.B.2. Comment Solicitation on the Annual Determination of the Impact of Differences Between Assumed Behavior Changes and Actual Behavior Changes on Estimated Aggregate Payment Expenditures under the HH PPS

As CMS developed its behavioral assumptions associated with PDGM implementation, it identified three features it took into consideration:

1. **Clinical Group Coding:** The clinical group is determined by the principal diagnosis code for the patient as reported by the home health agency (HHA) on the home health claim. This behavior assumption assumes that HHAs will change their documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day period be placed into a higher-paying clinical group.
2. **Comorbidity Coding:** The PDGM further adjusts payments based on patients' secondary diagnoses as reported by the HHA on the home health claim. The OASIS only allows HHAs to designate 1 principal diagnosis and 5 secondary diagnoses while the home health claim allows HHAs to designate 1 principal diagnosis and up to 24 secondary diagnoses. This behavior assumption assumes that by taking into account additional ICD-10-CM diagnosis codes listed on the home health claim (beyond the 6 allowed on the OASIS), more 30-day periods of care will receive a comorbidity adjustment.
3. **LUPA Threshold:** This behavior assumption assumes that for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold, HHAs will provide 1 to 2 extra visits to receive a full 30-day payment.

In addition to these features, ASHA recommends that CMS consider instances when little or no therapy is provided even when a therapy payment is triggered. ASHA also recommends reviewing trends unique to the characteristics associated with PDGM, such as a payment differential for the source of admission and timing of episodes, to ensure that patients maintain access to care and to uphold the regulatory and budget neutrality expectations of the payment system.

Section VI. Medicare Provider and Supplier Enrollment Changes

CMS proposes to codify in the Code of Federal Regulations guidance from the Medicare Program Integrity Manual related to Medicare enrollment. ASHA appreciates CMS's efforts to ensure consistency and clarity across the various forms of regulatory and subregulatory guidance provided to Medicare suppliers, including audiologists and SLPs, and supports the formal inclusion of the program integrity manual provisions in the regulations.

Section VIII.B. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs – Request for Information

ASHA commends CMS for 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 OASIS, capture data that providers and CMS may use to reduce health disparities in the areas of race, ethnicity, transportation, gender, and language access (e.g., interpreter, translated materials). While existing post-acute care assessment tools are beneficial, ASHA recommends that CMS collect additional forms of standardized patient assessment data (SPADEs) and use SPADEs to improve health outcomes. Providers must do more than report this data. Collection and use of health equity data by payers and health care providers may improve population health. For example, the data may be stratified by medically underrepresented groups to determine patient experience. If disparities are identified, then providers may implement strategies focused on improved outcomes of care, as well as 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 foundation of patient-centered care; 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:** Health insurance coverage has been identified as a key social determinant of health and is one of the largest barriers to health care access.⁴ 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, as well as patients who lack digital literacy, may not be able to receive timely and clinically appropriate care via telehealth. This barrier delays care and adversely impacts outcomes and quality of care.
- **Forms of economic insecurity such as housing or food insecurity:** Patients with one or more forms of economic insecurity may have to choose between medical care and other financial demands. The stress of such choices adversely impacts the patient's overall physical and mental health. When forced to choose, medical care may be a lower immediate priority despite the significant financial impact that delaying care may 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 must be assessed. Health literacy is not restricted to only a person's ability to read and write.⁵ Communication disorders cause difficulties with processing and using health information. Other factors that play a role in how well someone understands health information received 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 its impact on quality and outcomes, ASHA recommends sharing this information with providers via designated mechanisms (e.g., confidential feedback reports) to help further the goal of health equity. However, data sharing is not enough. Although providers in many settings, particularly post-acute care settings, have access to some of this data, it is unclear if the data is used in a meaningful way to improve the quality of care for patients.

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 may apply a payment penalty to providers who do not use health equity data to improve care for their patient populations or apply a bonus for those who do so systematically.

ASHA further 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 may 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 similar patient populations or risk adjusted accordingly.

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.

Sincerely,



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

¹ American Speech-Language-Hearing Association. (n.d.). *ASHA Membership Survey*. <https://www.asha.org/research/memberdata/membership-survey/>.

² American Speech-Language-Hearing Association. (n.d.). *Code of Ethics*. <https://www.asha.org/code-of-ethics/>.

³ Centers for Medicare & Medicaid Services. (2020) *The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)*. <https://www.cms.gov/files/document/se20005.pdf>.

⁴ Healthy People.gov. (n.d.). *Access to Health Services*. <https://www.healthypeople.gov/2020/topicsobjectives/topic/social-determinants-health/interventions-resources/access-to-health#3>.

⁵ American Speech-Language-Hearing Association. (n.d.). *Health Literacy*. <https://www.asha.org/slp/healthliteracy/>.