



June 7, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1748-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2022 and Updates to the IRF Quality Reporting Program

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments on the fiscal year 2022 inpatient rehabilitation facility (IRF) prospective payment system (PPS) proposed rule. ASHA members, particularly speech-language pathologists (SLPs), provide critical health care services to patients in IRFs. Our comments will focus on the request for information on closing the health equity gap.

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.

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

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 inpatient rehabilitation facility patient assessment instrument (IRF-PAI), 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 to also act on the information obtained from the data collection 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 can improve population health. 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.¹ 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. Health literacy is not restricted to only a person's ability to read and write.² 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

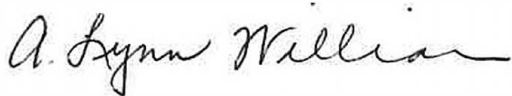
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cases, providers may misrepresent or misunderstand the data in the absence of the important context health equity metrics provide. For example, a hospital could present superior quality metrics in a particular geographic region as compared to its competitors. 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.

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 handwritten signature in cursive script that reads "A. Lynn Williams".

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

¹ 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>.

² American Speech-Language-Hearing Association. (n.d.) *Health Literacy*. <https://www.asha.org/slp/healthliteracy/>.