



ASHA
American
Speech-Language-Hearing
Association

June 9, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1765-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 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the skilled nursing facility prospective payment system proposed rule. ASHA's comments focus on three primary areas, including: 1) the request for information regarding overarching principles for measuring equity and health care quality disparities across CMS quality programs; 2) recalibration of the parity adjustment, and; 3) the request for information associated with staffing minimums.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

V. C. Recalibrating the PDPM Parity Adjustment

Approximately 30,000 ASHA members who are speech-language pathologists (SLPs) work in skilled nursing facilities (SNFs).¹ SLPs play a critical role in addressing the health care needs of patients in this setting. Therefore, ASHA has maintained an active role in the development, implementation, and monitoring of the Patient Driven Payment Model (PDPM). ASHA appreciates the collaborative approach CMS has taken in the development of this payment system, which is entering its fourth year, as PDPM addresses significant problems with the previous payment system, the Resource Utilization Group (RUG) IV. ASHA strongly supports value-based, patient-centered payment models, which is the intent of PDPM. However, while PDPM removed the unethical pressure to deliver high volumes of therapy to maximize reimbursement, it also created challenges for therapists' employment and patients' access to care in SNFs.

From the outset, ASHA has made it clear in meetings and written comments that active monitoring of Minimum Data Set (MDS) and claims data is critical to ensuring that patients maintain access to SNF care. For example, tracking both therapy minutes delivered and the mode of therapy (e.g., group, concurrent, individual) is important to ensuring that SNFs deliver therapy services in the most appropriate way when receiving a therapy payment. In the period between the release of the fiscal year (FY) 2020 final rule and the implementation of the payment system on October 1, 2019, ASHA members reported numerous problematic trends in SNFs in response to the transition. These trends continued until the early part of the federally declared COVID-19 public health emergency (PHE) in January 2020. ASHA conducted a member experience survey and 38% of SLP respondents stated that they had experienced a reduction in hours or a change in employment status from full-time to part-time. In addition, 46% of respondents indicated their caseload in SNFs had decreased.² Workforce and administrative reductions, such as these, limit access to care for Medicare beneficiaries in SNFs.

CMS data also reflects troubling changes in service delivery patterns, which validates ASHA member reports of reduced employment opportunities. ASHA maintains that this data will help inform the next steps for optimizing PDPM to ensure patient access to quality care. A reduction in therapy provision was anticipated by stakeholders while transitioning from a volume-based to value-based payment system. However, CMS outlined a reduction of nearly 30% in therapy services during the first three months of PDPM implementation in both the FY 2022 and FY 2023 proposed rules. This 30% reduction in therapy provision shows a decrease from an average of 93 minutes per patient per day to 68 minutes per patient per day. While some quality metrics, such as hospital readmissions or falls, do not appear impacted by these shifts in service delivery, data in the FY 2023 proposed rule indicates more granular metrics of quality may have been negatively impacted. CMS data show that in the first three months of the PDPM transition, prior to the PHE declaration, SNF patients experienced higher levels of mood distress, cognitive decline, change in appetite, and weight loss requiring diet modifications. ASHA maintains that some metrics, such as hospital readmissions, are not granular enough to adequately gauge patient experience and outcomes of care, particularly related to communication disorders.

To further understand the impact of the PDPM transition on SNF patients, ASHA is engaged with patient advocacy organizations to gain consumers' perspective. ASHA has held regular meetings with these organizations over the last two years to exchange information and identify any emerging trends associated with the transition to PDPM. ASHA also developed a consumer and physician factsheet to help dispel certain myths associated with the transition to PDPM and ensure patients maintain access to care in SNFs. ASHA is committed to ensuring the patient voice is represented in any efforts to revise the SNF payment system. Without this engagement, changes may lead to unintended consequences for patients.

CMS's internal data and ASHA's membership survey data link the change in the payment model to reduced access to care, which has contributed to poorer clinical outcomes for SNF patients. ASHA recognizes the importance of budget neutrality to protect the Medicare trust fund. However, when faced with changes in payments, many SNFs respond by cutting care instead of identifying ways to comply with the legal and regulatory requirements of the payment system that would ensure patient access to care and quality outcomes. As a result, ASHA expects that implementation of a parity adjustment would lead to further reduction in care delivery and decreased access to and outcomes of care for SNF patients. Therefore, ASHA asserts that it is premature to implement a parity adjustment until CMS gains an understanding of how to strengthen the payment system requirements to ensure service delivery decisions reflect patient care needs.

In the FY 2022 rulemaking cycle, ASHA supported options to target the parity adjustment to SNFs that most egregiously violate CMS's budget neutrality expectations or regulatory requirements. ASHA is committed to ensuring that SNFs in compliance with Medicare program requirements and preserve access to care for patients are not subject to significant payment reductions. For example, ASHA asked for more granular quality and outcomes metrics and CMS responded by sharing data around elective surgeries and mood, cognitive, and diet changes among other metrics. ASHA also supported identifying a mechanism by which CMS could create accountability mechanisms for violations of its regulatory requirements, such as exceeding the 25% limitation on group and concurrent therapy or routinely receiving a therapy payment while delivering little or no therapy. Nearly 20% of respondents to ASHA's 2021 SLP health care survey reported that they were pressured to provide group treatment despite their belief that individual therapy was more appropriate based on the patient's clinical presentation.³ ASHA fully supports the use of group and concurrent therapy as an important component of service delivery when clinically appropriate (i.e., based on individualized assessment of the patient's needs). ASHA notes that the use of group and concurrent therapy appropriately dropped during most of calendar years 2020 and 2021 to mitigate the risk of COVID-19 transmission. However, ASHA is committed to ensuring that SNFs who are not complying with CMS's expectations are most impacted by any negative payment adjustments. Therefore, ASHA reiterates its recommendation for CMS to monitor compliance with the 25% limitation on group and concurrent therapy, especially as we move toward COVID-19 endemicity, and use that metric and similar data to implement any payment reductions to targeted SNFs.

In response to recommendations to target the parity adjustment to SNFs that exceeded CMS's projections, CMS proposes a second option, which would target speech-language pathology, nursing, and non-therapy ancillary (NTA) services for a reduction rather than applying a parity adjustment across all SNF case-mix groups. ASHA strongly opposes targeting the parity adjustment to select service categories, such as speech-language pathology. Through the PDPM TEP and associated report, CMS made it clear that enhancing the accuracy of payment for nursing and NTA was an important component of revising the payment system. Under RUG-IV, where therapy utilization often drove care decisions and reimbursement, nursing and NTA services appeared to be an afterthought despite their critical importance to patients. In addition, ASHA's TEP representative provided evidence that speech-language pathology services were undervalued in the RUG-IV system, which contributed to CMS's decision to provide a speech-language pathology comorbidity payment and exclude speech-language pathology services from the variable per diem payment applied to physical and occupational therapy services. By identifying these deficiencies in the RUG-IV payment system, a more accurate representation of these service on the MDS and claims was made available, which provided an opportunity to financially incentivize this level of accuracy for the first time. As a result, utilization of speech-language pathology services appropriately meets beneficiary needs under PDPM. ASHA believes that this level of service delivery is consistent with RUG-IV but not previously reported on the MDS since there were no "financial incentives" for SNFs to report it under the previous payment system.

In practice, increased utilization does not equate to waste, fraud, or abuse but rather reflects improved coding and documentation of patient needs. With the transition to PDPM, ASHA undertook an extensive member education campaign to ensure SLPs working in SNFs were aware of the payment system requirements and how they could play an effective role in enhancing SNF patient access to care. ASHA emphasized to its members the importance of accurate and comprehensive coding on the MDS, claims, and in the medical record. ASHA members responded in large part by integrating themselves into multidisciplinary care teams to

capture the full range of patients who benefit from speech-language pathology services. Thus, the proposal to target speech, nursing, and NTA services with a parity adjustment runs counter to the intention underlying this payment system; namely to ensure patients receive important, medically necessary health care services, and reduce the volume of unnecessary services not tied to individual patient needs. Reducing payment because a SNF delivered appropriate nursing, NTA, or speech-language pathology services will only exacerbate the problem of arbitrary service delivery reductions to meet financial goals of companies and ownership groups. Such a proposal runs counter to the intent of PDPM and undermines efforts to ensure care delivery is based on an individualized assessment of patient needs.

ASHA encourages CMS to consider targeting the parity adjustment to SNFs with changes in ownership such as, but not limited to, private equity (PE) investment. Changes in ownership can be correlated with changes in service delivery and negative health outcomes. Targeting *bad actors* is a more appropriate method for achieving budget neutrality instead of a blunt, across the board payment reduction, which negatively impacts SNFs who have complied with CMS's regulatory and budget neutrality expectations.

According to the June 2021 Medicare Payment Advisory Commission (MedPAC) Report, approximately 11% of nursing homes are owned by PE firms. Many PE firms use management strategies designed to improve profitability, often to the detriment of the Medicare program and patients. ASHA recommends that CMS identify mechanisms to track the impact of PE ownership for the purpose of targeting a parity adjustment. These management strategies may include:

- increasing volume;
- *cherry-picking* patients (e.g., excluding Medicaid patients, limiting certain diagnoses, excluding patients entering from community settings) that comprise their patient case-mix;
- horizontal integration among companies owned by the PE firm (e.g., requiring the SNF to purchase PPE from another entity owned by the PE firm),
- reducing staff or changing the composition of staff (e.g., using assistants or aides rather than a therapist or nurse); and
- performance-related pay, which might spur inappropriate service delivery.

According to the summarized findings of research included in the MedPAC report, the impact of PE ownership can be mixed but correlates with increased mortality, worsening mobility, elevated use of antipsychotic medications, declines in nurse availability per patient, and declines in compliance with federal and state standards of care.⁴ The current Administration has also highlighted the relationship between PE ownership and problematic trends that deserve attention including:

- residents in nursing homes acquired by PE firms were 11.1% more likely to have a preventable emergency department visit and 8.7% more likely to experience a preventable hospitalization, when compared to residents of for-profit nursing homes not associated with PE;
- PE ownership increased mortality for residents by 10%, increased prescription of antipsychotic drugs for residents by 50%, decreased hours of frontline nursing staffing by 3%, and increased taxpayer spending per resident by 11%;
- PE-backed nursing homes' COVID-19 infection rate and death rate were 30% and 40% above statewide averages, respectively.⁵

In conclusion, ASHA recommends that CMS not implement a parity adjustment until the following issues have been addressed:

1. Understanding the impact of payment changes, such as implementation of PDPM, on patient access to and quality of care. CMS could consider specific outreach to patient advocacy organizations to ensure the needs and challenges of their members are known and factored into the refinement of PDPM moving forward;
2. Determining compliance with regulatory requirements outside of the COVID-19 PHE; and
3. Refining the targeting criteria including determining the impact of changes in ownership on Medicare payments and monitoring the impact of PE ownership on increases in negative patient outcomes.

VI. E. Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs—Request for Information (RFI)

ASHA thanks CMS for seeking to ensure that Medicare providers address health equity to improve the quality and outcomes of care for their patients. ASHA has responded to previous RFIs on this topic, and both appreciates and shares the continued commitment by CMS to address health equity and health care disparities.

1. Cross-Setting Framework to Assess Healthcare Quality Disparities

CMS seeks feedback on the methodology that can present stratified measure results; within-hospital disparity or between-hospital disparity. ASHA recognizes that using both methodologies paint a more complete picture. The within-hospital methodology examines how well facilities achieve equitable outcomes among their patients while the between-hospital methodology examines how patients with social risk factors fare at different facilities. The combination of both methodologies gathers two different pieces of useful information.

Existing quality measures that already meet established psychometric property thresholds are a potential source of health disparity information when the data is stratified by groups with social risk factors. Data stratification is a common methodology to assess varying outcomes and determine predictive factors. Therefore, ASHA supports stratifying existing clinical quality metrics to measure health disparities – an action that allows for the maintenance of existing measures will not unnecessarily increasing the reporting burden.

ASHA acknowledges that statistical reliability and representative sampling are important but may prove difficult (depending on census composition) for facilities to maintain with fluctuating demographics. Therefore, ASHA recommends that any representation standards be applied over the duration of the performance year to maximize the chance of capturing data on individuals with social risk factors.

In addition, ASHA recommends that CMS clarify: 1) if SNFs are encouraged or compelled to report measures that show differences between subgroups; and 2) how these measures would be identified. If SNFs are allowed to select these measures, ASHA is concerned that SNFs might select measures that portray the most positive quality outcomes rather than those measures which provide a clear understanding of the strengths and challenges a particular SNF faces. CMS might consider identifying the reported measures in advance based on priorities for quality improvement.

ASHA also supports the collection of additional standardized patient data elements to address health equity but recognizes the additional administrative burden this imposes on post-acute

care providers. ASHA recommends that consideration be given to the interoperability of electronic health records (EHRs) and CMS assessment tools, such as the MDS, to prevent redundant demographic information collection from contributing to clinician reporting burden.

In terms of identifying meaningful performance differences, audiologists and SLPs are familiar with statistical approaches and defined thresholds for quality benchmarking because of their frequent use in standardized assessments and ASHA's data registry, the National Outcomes Measurement System (NOMS). However, ASHA is concerned that a ranking system may not be as consumer friendly as defined thresholds because the "rank" will depend on several participating providers.

ASHA agrees that it is important to report stratified measure data alongside overall measure results. Reporting both stratified measure data and overall measure results more clearly identifies gaps in outcomes for subgroups within a specific facility. For example, by reviewing overall measure results along with stratified results, additional details about the quality of care for subgroups of patients may be seen; thereby, providing insight to drive quality improvement. The combination of reporting more clearly identifies gaps in outcomes for subgroups within that specific facility.

2. Approaches to Assessing Drivers of Healthcare Quality Disparities and Developing Measures of Healthcare Equity in the SNF QRP

ASHA supports CMS' approach to performance disparity decomposition as it will likely produce valuable data for analysis and minimize administrative burden on SNFs.

ASHA recommends CMS clarify that the Health Equity Summary Score (HESS) score is applied to the SNF, not to individual clinicians within the SNF, given that numerous factors contribute to a HESS score that are outside an individual clinician's control in a facility setting.

VII.I.c.3 Request for Comment on the Validation of SNF Measures and Assessment Data

CMS requests feedback on data validation methods and procedures that can ensure data element validity and accuracy for both measures and assessment data. ASHA recommends for CMS to confirm, in future technical assistance documents or guidance language, that the multidisciplinary care team can and should participate in the completion of the MDS. ASHA knows that when each member of the multidisciplinary team is engaged in completion of the MDS, all the patient's needs will be more accurately identified in a timely fashion than if a single individual completes the MDS. CMS will have a more accurate and robust data set upon which to understand the types of patients treated in SNFs, their resource use, and outcomes when a SNF uses a multidisciplinary approach to completing the MDS.

VII. Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

The evolution of the value-based purchasing program (VBP) in SNFs is important to recognizing the value of speech-language pathology services and ensuring that patients maintain access to care. ASHA agrees with CMS's proposal to suppress the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) for the FY 2023 program year due to fewer admissions to SNFs, regional differences in the prevalence of COVID-19, and changes in hospitalization patterns seen in FY 2021. Because the SNF VBP has only one measure, Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR), quality cannot be

fairly assessed during the PHE. ASHA also supports the inclusion of more granular metrics, which capture a variety of areas associated with communication and swallowing needs.

ASHA also understands CMS's proposal to reduce each participating SNF's adjusted federal per diem rate for FY 2023 by 2% and award each participating SNF 60% of the 2% withheld. While not an ideal solution, ASHA maintains it is the most equitable solution given the PHE.

CMS also proposes to exclude SNFs that do not report a minimum of 25 eligible stays for the SNFRM for the FY 2023 program year from the SNF VBP for that year. As a result, the payback percentage for FY 2023 would remain at 60%. ASHA supports this approach as it is similar to other Medicare quality reporting policies, such as those in MIPS, with the inclusion of a minimum threshold for participation.

Beginning in FY 2023, CMS proposed to provide quarterly confidential feedback reports to SNFs and to publicly report the SNFRM rates for the FY 2023 SNF VBP Program Year. ASHA is concerned that patients will not understand the nuance of the publicly reported information based on suppressed measures. As a result, ASHA recommends that CMS begin with providing confidential feedback reports to give SNFs the opportunity to understand and utilize these reports in their quality improvement initiatives but delay public reporting until the suppression of these measures is eliminated.

Beginning in FY 2024, CMS proposes its methodology for calculating VBP performance scores that would serve as the basis for incentive payments. ASHA does not have concerns regarding the scoring methodology, but it recommends that CMS delay calculating performance until the end of the federal PHE to ensure more accurate and equitable data given the variations related to the COVID-19 impact noted above in our comments.

Beginning in FY 2026 and FY 2027, CMS suggests the addition of new VBP measures. Specifically, in FY 2026 CMS proposes two measures: 1) SNF Healthcare Associated Infections (HAI) Requiring Hospitalization (SNF HAI) measure; and 2) Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing) measure. ASHA acknowledges the value of these measures in improving patient safety; however, ASHA maintains that these new VBP measures are not granular enough to fully understand the outcomes and quality of care—particularly for patients requiring audiology and speech-language pathology services. For the FY 2027 program, CMS proposes adopting the Discharge to Community (DTC)—Post-Acute Care (PAC) Measure for Skilled Nursing Facilities (NQF #3481). This measure is important to ensure a successful transition from the facility to the community because it incorporates 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 risk, safety awareness, and money management.

ASHA strongly encourages CMS to adopt the measure for the FY 2027 VBP.

VIII. Request for Information: Revising the Requirements for Long-Term Care (LTC) Facilities to Establish Mandatory Minimum Staffing Levels

ASHA appreciates the opportunity to respond to the RFI on mandatory minimum staffing levels. ASHA recognizes that establishing minimum staffing levels is a challenging task and multiple factors, such as fluctuating patient census levels and clinical needs, complicates developing those minimums. Throughout the RFI, CMS identifies the need to understand staffing minimums for a variety of direct care staff given existing regulations in §483.35 that require long-term care (LTC) facilities to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. CMS specifically emphasizes the critical role of therapists, including SLPs, in ensuring SNFs help patients “attain or maintain the highest practicable physical, mental, and psychosocial well-being.” Changes in patient demographics highlighted in the rule include issues that SLPs are trained and able to address, such as increased patient acuity and decreased functional ability to perform activities of daily living, further reinforcing the importance of considering the development of minimum therapy staffing levels.

ASHA maintains that it is premature to impose a speech-language pathology staffing minimum, and more collaborative work is needed with CMS and consumer advocates to determine if staff minimums may be developed and structured in such a manner to ensure a safe working environment and optimal patient care. As CMS considers the development of staffing minimums, it is critical to ensure separate minimums for each clinical specialty. It would be inappropriate to lump several or all clinical specialties into one “direct care” staffing minimum. A joint “therapy staffing” minimum would be equally inappropriate. And, while multiple clinical specialties may address a particular impairment, such as swallowing impairment or cognitive decline, each specialty has specific skills that are not interchangeable. Therefore, ASHA strongly recommends a separate minimum staffing requirement for each distinct service (e.g., nursing, speech-language pathology, physical therapy).

In addition, it is not appropriate to incorporate direct care support services (e.g., delivering meals, bathing patients) provided by SLPs in nursing staff requirements. While SLPs recognize the need to assist with these types of activities during times of crisis (e.g., pandemic), to expect clinicians with the level of clinical training SLPs possess to routinely perform these activities is not appropriate. It would detract from the SLPs’ ability to provide important, skilled, speech therapy services to SNF patients and further complicate their ability to meet the productivity standards typically imposed by their employer.

As noted above, ASHA remains significantly concerned that layoffs and a reduction in hours for SLPs have impacted access to and the quality of care for SNF patients. ASHA notes the reports of layoffs and salary reductions as well as speech-language pathology staffing shortages in post-acute settings. ASHA recognizes these shortages are a result of many factors, including the physical and emotional toll of the COVID-19 pandemic, but all stakeholders need to address the problem of reactive employment policies directly resulting in subsequent staffing shortages. Setting appropriate staffing minimums may be a mechanism to address problematic administrative decisions that are driven by profit and directly contribute to reduced access to patient care and negative patient outcomes.

Unfortunately, staffing shortages are also compounded by poor working conditions. Many SLPs work in supportive skilled nursing environments where they are allowed to utilize their clinical judgment to meet the needs of their patients. However, there are ASHA members who report leaving post-acute care for education settings or to leave the profession entirely due to factors including administrative mandates circumventing clinical judgment, unmanageable productivity standards, low pay, lack of full-time employment opportunities, and lack of benefits and supports

such as mentorship programs. Twenty-six percent of SLPs who work in SNFs indicated they were considering a change in employment within the next five years but may be unable to due to personal circumstances. In addition, 25% stated they plan to leave a SNF and move to a different setting (e.g., private practice, hospital), and 13% indicated they would leave the profession entirely. Overall, 64% were contemplating leaving the sector.

The reasons for leaving SNFs included:

- Not feeling valued by other types of professionals or by administrators (32%)
- Unsatisfactory salary/benefits (30%)
- High productivity demands (32%)
- Unstable work hours (24%)
- Direct or indirect effect of COVID-19 (20%)
- Low/unsustainable caseload (17%)

ASHA's member surveys clearly indicate that action needs to be taken now to prevent the further loss of speech-language pathology employment in SNFs.⁶

ASHA provides responses to the following questions in the RFI.

1. *Is there evidence (other than the evidence reviewed in this RFI) that establishes appropriate minimum threshold staffing requirements for both nurses and other direct care workers? To what extent do older studies remain relevant? What are the benefits of adequate staffing in LTC facilities to residents and quality of care?*

ASHA acknowledges research associated with speech-language pathology staffing minimums is limited and, therefore, cannot recommend specific staffing levels at this time. However, ASHA maintains that changes in service delivery patterns since implementation of PDPM and the impact on patient access to care and related outcomes demonstrate the need to determine if staffing minimum recommendations could be made at a later date.

2. *What resident and facility factors should be considered in establishing a minimum staffing requirement for LTC facilities? How should the facility assessment of resident needs and acuity impact the minimum staffing requirement?*

ASHA recognizes that case mix and census of SNFs fluctuate. ASHA recommends that CMS take into consideration if 1) fluctuations in census and case mix should influence staffing minimums and 2) if these minimums can be adjusted as needed to respond to such changes. Fluctuations might be particularly challenging for small SNFs and/or SNFs in rural and medically underserved areas, therefore, special consideration should be given to these types of facilities in establishing staffing minimums.

Given the transition from a pandemic to an endemic state is still underway and staffing shortages as well as census variation remain challenges for the SNF industry, ASHA recommends for CMS to consider if it should establish a "pilot" period or waive enforcement for a specified period after implementation (e.g., one year) to allow for the identification of unexpected challenges or unintended consequences. ASHA is committed to a staffing policy that ensures patients receive access to care and avoids penalizing SNFs who make good faith efforts to comply with a necessary staffing requirement.

4. *What factors impact a facility's capability to successfully recruit and retain nursing staff? What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff? What risks are associated with these strategies, and how could nursing homes mitigate these risks?*

ASHA's 2021 survey of SLPs working in health care settings highlights the significant impact of SNF productivity standards on their professional satisfaction and ability to treat patients ethically and effectively. Ninety-five percent of SLPs working in SNFs who participated in ASHA's survey report that they are subject to a productivity requirement and this requirement is on average 85%; most of which do not include time for documentation or interdisciplinary consultation and other requirements and standards of care within their measure of "productive time".

Despite the importance of strong documentation for ensuring the efficacy and quality of care as well as protecting the SNF against liability claims and audit recoupments, only 8% of SLPs report that documentation time is factored into their productivity requirement. Multidisciplinary team care planning is also woefully absent in these standards as only 7% of SLPs report credit for participating in clinical team meetings and only 9% of productivity standards account for coordinating care activities.

As a result of productivity standards that do not account for the time spent on critical health care tasks (e.g., documentation, care planning), 21.6% of ASHA members who report they "work off the clock" do so daily and an additional 19% do so at least a few times a week. The additional strain of working off the clock is not sustainable and often illegal.

ASHA appreciates that productivity standards are industry developed and that CMS cannot dictate those standards; however, CMS must be aware of them and the negative impact they have on patient care and staff retention. For many years, ASHA discussed the impact of inappropriate productivity standards on workforce and patient care within the SNF industry and has argued for the development of productivity standards that meet the needs of SNFs, its employees, and their patients. ASHA firmly believes that developing productivity standards that 1) allow SLPs to effectively treat SNF patients and 2) recognizes SLPs for their contributions to both improving the quality of care for patients as well as the profitability for SNFs, would mitigate the industry staffing shortages. ASHA is committed to assisting the SNF industry in the development of appropriate productivity standards inclusive of all the work and expertise that is valuable to patient care, quality, and outcomes to address industry recruitment and retention challenges.

In addition, ASHA members report pressure to engage in unethical behavior in SNFs. Nineteen percent of SLPs in SNFs report they are pressured to provide inappropriate frequency or intensity of services, 22% report they are told to discharge patients inappropriately (i.e., either early or delayed), and 21% report they are instructed to provide evaluation and treatment that is not clinically appropriate based on the patient's clinical presentation. ASHA has developed and distributed member education resources to provide SLPs with the facts on Medicare requirements for service delivery in SNFs to empower them in an effort to avoid and push back against unethical mandates. However, ASHA encourages CMS to continue to monitor claims and MDS data to identify trends that might be reflective of such mandates as soon as possible and

determine appropriate enforcement mechanisms to help prevent and reduce unethical working conditions. Improving these conditions could help progress our shared goal of improving recruitment and retention of SLPs and other essential staff in SNFs.

5. *How should administrative nursing time be considered in establishing a staffing standard? Should a standard account for a minimum time for administrative nursing, in addition to direct care? If so, should it be separated out?*

As noted above, administrative tasks such as documentation and multidisciplinary team care planning are critical to meeting patient needs, protecting the SNF from liability claims, and maintaining profitability for the SNF. Accurately capturing the full range of services that a patient needs could lead to increased reimbursement. Strong documentation can also prevent post-payment denials. Yet, SNF productivity standards fail to reflect these realities. Many productivity requirements still focus on service delivery time as driven by the utilization focus on RUG-IV instead of the requirements in the current patient-driven system. As CMS considers minimum staffing standards for additional clinical specialties, such as speech-language pathology, administrative time should be reflected to ensure SNFs appropriately value such work.

6. *Have minimum staffing requirements been effective at the State level? What were facilities' experiences transitioning to these requirements? We note that States have implemented a variety of these options, discussed in section VIII.A. of this proposed rule, and would welcome comment on experiences with State minimum staffing requirements.*

Three states (Illinois, Rhode Island, and Arkansas) have established direct care staffing minimums for nursing homes that explicitly include SLPs. Other states have not provided detailed lists or definitions of direct care staff in establishing staffing minimums but could potentially count SLPs for these purposes. ASHA is monitoring the development of minimum staffing requirements at the state level and will share updated information as it becomes available. ASHA is also engaging SLPs in states with a staffing minimum to determine the impact on working conditions and patient care.

In conclusion, ASHA is committed to partnering with CMS and the SNF industry to determine if staffing minimums will help ensure patient needs are met and help improve service delivery within SNFs. Additional work is needed to understand the impact of specific staffing requirements on the SNF workforce and patient care.

Thank you for the opportunity to comment on this proposed rule. If you or your staff have questions regarding these comments, please contact Sarah Warren, ASHA's director of health care policy for Medicare, at swarren@asha.org.

Sincerely,


Judy Rich, EdD, CCC-SLP, BCS-CL
2022 ASHA President

¹ American Speech-Language-Hearing Association. (2021). *SLP Health Care Survey Summary Report*. <https://www.asha.org/siteassets/surveys/2021-slp-health-care-survey-summary-report.pdf>.

² Ibid.

³ Ibid.

⁴ Medicare Payment Advisory Commission. (2021). *Report to Congress. Chapter 3: Private Equity and Medicare*. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf.

⁵ White House. (2022). *White House Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes*. <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>.

⁶ American Speech-Language-Hearing Association. (2021). *SLP Health Care 2021 Survey Summary Report*. <https://www.asha.org/siteassets/surveys/2021-slp-health-care-survey-summary-report.pdf>.