



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

June 25, 2018

Seema Verma, MPH  
Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Attention: CMS-1696-P, Mail Stop C4-26-05  
Baltimore, MD 21244

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the proposed rule modifying payments to skilled nursing facilities (SNFs) for fiscal year (FY) 2019, including the patient driven payment model (PDPM).

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

Speech-language pathologists (SLPs) who provide services to Medicare beneficiaries in SNFs would be significantly impacted by the revisions to the prospective payment system (PPS) under the PDPM proposal. ASHA's goal is to ensure that access to speech-language pathology services is preserved while the prospective payment system (PPS) is appropriately structured and incentivizes SNF payment to ensure quality service delivery and outcomes.

ASHA's comments address the following issues raised in the proposed rule:

1. PDPM as an Alternative Payment Model
2. Group and Concurrent Therapy Limitations
3. Revised Assessment Schedules
4. Mechanically Altered Diets
5. Use of Section GG
6. Use of ICD-10 and Speech-Language Pathology Comorbidities
7. Development of an Accountability Mechanism to Ensure Therapy is Provided Appropriately

### **PDPM as an Alternative Payment Model**

In the proposed rule, CMS highlights PDPM as an example of an alternative payment model because of its focus on patient characteristics, value, and quality. The existing SNF PPS is structured around a focus on patient characteristics with an additional fee-for-service payment

based on the provision and amount of certain types of services (e.g., therapy) that a patient requires. Alternative payment models represent alternatives to fee-for-service payment. Fee-for-service has received criticism for paying for volume rather than value. Quality is an integral component of alternative payment models and, while SNFs are subject to a quality reporting program (QRP), **ASHA requests that CMS clearly articulate how the PDPM and the QRP are interrelated.** Emphasizing quality and outcomes will help ensure the payment system rewards appropriate and high quality care.

### **Group and Concurrent Therapy Limitation**

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes to restrict group and concurrent therapy to 25% over the episode of care for each patient, combined. CMS data on the limited use of these modes of therapy is just over 1% combined (on average, nationally); therefore, it is unclear why the proposed restriction is necessary. ASHA maintains that the needs of the patient, the patient's clinical condition, and the clinical judgment of the SLP should determine the mode of therapy and the appropriate level of use for each mode of therapy rather than an arbitrary restriction. CMS has not provided data or research justifying that 25% (or any other level) is appropriate. ASHA is concerned that SNFs may provide as much therapy as possible, via group and concurrent therapy, up to any finalized restricted level in an effort to reduce staffing costs rather than restricting the use of these modes of therapy. ASHA maintains this is not in the patient's best interest and encourages CMS to establish a means to assure the professional discretion of the clinician and the patient's medical needs as the only criteria used to determine the type of treatment provided. **ASHA requests that CMS does not impose an arbitrary restriction on the use of group and concurrent therapy until better data on its appropriate use is available. ASHA also urges CMS to monitor the utilization of concurrent and group therapy to ensure consistency with the beneficiary's individualized plan of care.**

Additionally, services delivered by a therapy student under the supervision of a licensed clinical supervisor has been counted as "concurrent" on the minimum data set (MDS). This occurs when the supervising therapist is treating another patient at the same time, per the MDS instructions. Therefore, it is possible that if a SNF accepts a higher number of students (either for internal goals or their proximity to training programs), the average of 1% for group and concurrent therapy represented in CMS data may not prove accurate. In SNFs with a higher than average number of students, the percentage of time spent delivering concurrent therapy could be higher, in excess of 25%. This could potentially have a significant impact on the ability of SNFs to train therapy professionals leading to future 'access to care' issues for Medicare beneficiaries. CMS should consider the impact a limitation, such as 25%, on the delivery of therapy in a group or concurrent manner could have on those SNFs who take on a high volume of therapy students.

### **ASHA requests flexibility in how the delivery of these modes of therapy are regulated.**

Currently, 'group' is strictly defined as exactly four patients. This creates challenges when one of the four patients in the group is unexpectedly absent from therapy (e.g., when a patient is ill). Instead, ASHA encourages CMS to define 'group' as 2-6 patients performing the same or similar tasks under the supervision of one therapist, such as an SLP.

### **Revised Assessment Schedules**

CMS proposes to eliminate all assessments with the exception of an admission and discharge MDS and a new type of assessment known as the interim payment assessment (IPA). ASHA supports eliminating most assessments as they unnecessarily increase the burden on SNFs, clinicians, and patients without providing clinically significant data. However, ASHA remains concerned about stinting care for residents who might reside in a SNF for 30-days or longer because these patients tend to be clinically complex and require a greater degree of care. **ASHA recommends that CMS consider an assessment to track long-stay residents periodically, such as every 30-days, to maintain access to medically necessary services for these patients and ensure the delivery of therapy built into the prospective payment for that beneficiary's category.**

Despite ASHA's general support for a reduced number of assessments, the IPA may not be a sufficiently effective mechanism to capture changes in a patient's clinical condition. As outlined in the proposed rule, the IPA should only be conducted under two circumstances:

1. There is a change in the resident's classification in at least one of the first tier classification criteria for any of the components under the proposed PDPM (clinical or nursing payment criteria identified in the first column in Tables 21, 23, 26, and 27) that would result in:
    - a. the resident being classified into a group for a component that differs from that provided by the 5-day scheduled PPS assessment; and
    - b. a change in payment either in one particular payment component or in the overall payment for the resident;
- and**
2. The change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14-day period.

The average length of stay for a SNF resident is often less than 20-days. As a result, depending on when a change in status occurs, the 14-day timeframe associated with completing the IPA might preclude a SNF from receiving appropriate financial recognition for an increased cost in care for a particular patient. **Therefore, ASHA recommends that CMS shorten the 14-day threshold.**

ASHA understands that the concept of the IPA was developed to address concerns and criticisms with the significant change in status assessment. Many stakeholders believed that, as defined, it was not clear when this assessment would be completed; therefore, it was rarely completed. It appears that the criteria associated with the IPA makes it equally unlikely for the assessment to be completed, particularly as it relates to the timeframe for completion and the significant bar that must be met in order to achieve a higher payment even when the patient's clinical condition may require it. ASHA is concerned that instead of "solving" the problems associated with the significant change in status assessment, this proposal compounds them. Allowing a lower threshold for the number of days in which the assessment must be completed and including changes in the clinical condition as well as changes in functional status may help ensure the IPA proves useful for all stakeholders both in directing clinical care and related payment.

ASHA has concerns about the interaction between the interrupted stay policy and the IPA completion requirements and asks CMS to determine if the structure of these two payment policies contradict each other and if any changes would be appropriate if they do.

### **Mechanically Altered Diets**

During the development of the resident classification system-1 (RCS-1), ASHA was pleased that CMS and its contractor recognized the increased cost and service use of patients who need a mechanically altered diet and included that as part of the case mix. However, ASHA recognizes that inclusion of mechanically altered diets as a payment determinant had the potential for manipulation. It was possible that a SNF could put patients who did not require a mechanically altered diet on such a diet or keep patients on such a diet longer than was clinically necessary. In the proposed rule, CMS notes it will be monitoring the use of mechanically altered diets to determine a significant, and potentially unwarranted, increase in the use of such diets in a manner that indicates an inappropriate manipulation of the payment system.

**ASHA supports both the inclusion of mechanically altered diets as a factor for payment and monitoring of the use of mechanically altered diets to avoid inappropriate activity on the part of the SNF.** ASHA looks forward to working with CMS to monitor the implementation of this proposal and suggest mechanisms for evaluating the clinical appropriateness of any resulting variations that might indicate SNF administrative mandates are interfering with clinical judgement. CMS could also consider adding items to the MDS to more effectively track swallowing impairment.

### **Use of Section GG**

Although ASHA maintains that the adoption of Section GG on the MDS ensures the accuracy of the payment system and assesses the needs of patients, ASHA recognizes that it is a significant change in the way the MDS has been completed. Historically, the MDS has been completed by a MDS Coordinator who is usually a nurse with a clinical background who is not specifically suited for determining rehabilitation needs and goals related to communication, swallowing, and cognition. The use of Section GG requires the clinical input of speech-language pathologists, physical therapists, and occupational therapists. ASHA has heard anecdotally from members that they have already been required to complete or participate in the completion of Section GG. In addition, ASHA maintains that Section GG upholds an important obligation of CMS to implement the Improving Post-Acute Care Transformation (IMPACT) Act.

**It is important for CMS to work with stakeholders and provide adequate training and education to ensure SNFs and their clinical staff are prepared to comply with the requirements of Section GG.** Due to the change in the process for completing the MDS, members of the interdisciplinary care team will need to be involved.

### **Use of ICD-10 Data as a Basis of Payment and Speech-Language Pathology Comorbidities**

ASHA has numerous concerns about the use of ICD-10 codes for the PDPM. Many SNFs lack staff with expertise in this coding system. If CMS finalizes this proposal, it should ensure adequate time and training is provided. In addition, gaining timely access to the ICD-10 code(s) associated with the prior hospitalization from the discharging hospital is often a challenge. In

some cases, a SNF does not receive this information until after a patient is discharged from the facility.

ASHA recommends that CMS consider adding a checklist of items to Section I of the SNF PPS admission MDS for providers to report the primary condition for physical therapy, occupational therapy, and speech-language pathology component classification, as well as comorbidities and conditions that apply to the speech-language pathology and non-therapy ancillary (NTA) component classification, which are not currently captured on the SNF PPS admission MDS.

- This recommendation would not preclude providers from entering ICD-10-CM codes into Section I8000 of the MDS (as proposed) that map to any of the physical therapy, occupational therapy, speech-language pathology, or NTA condition or comorbidity groups if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently.
- This recommendation would not change existing ICD-10-CM principal claim diagnosis reporting requirements that are subject to the submission of fully-specified ICD-10-CM codes per Medicare administrative contractor (MAC) claims-processing and Local Coverage Determination (LCD) coding policies.

ASHA acknowledges and appreciates the inclusion of comorbidities in the consideration of classification of patients for speech-language pathology services. However, the use of amyotrophic lateral sclerosis (ALS) as the only comorbid progressive neurologic disease to qualify a patient for speech-language pathology services is inconsistent with our understanding of the patient population being treated through SNFs. ASHA asks for ALS to be replaced with “Progressive Neurologic Diseases” as an acceptable comorbidity to qualify a patient for speech-language pathology services. This would allow for the SNF population with progressive diseases such a Parkinson’s or multiple sclerosis to qualify for speech-language pathology classification.

### **Development of an Accountability Mechanism to Ensure Therapy Is Provided Appropriately**

In the proposed rule, a SNF would receive a therapy payment (physical therapy, occupational therapy, and/or speech-language pathology) if the patient’s clinical characteristics, such as comorbidities, and clinical diagnosis indicate that therapy services are likely to be warranted. Payment is provided regardless of whether therapy services are actually provided. **ASHA is concerned that SNFs will manipulate this payment approach to achieve the maximum therapy payment but not provide all of the medically necessary therapy the beneficiary requires.** As a result, ASHA has long advocated for an accountability mechanism to ensure that CMS is aware when therapy is not provided, such as the use of Section O of the MDS. This accountability mechanism becomes increasingly important if CMS finalizes the proposal to restrict or, as suggested earlier, elevate the use of group and concurrent therapy to 25%. ASHA recognizes that there may be instances that should be accounted for through documentation when therapy cannot be provided. For example, if the patient refuses treatment on a particular day or perhaps therapy is contraindicated at a given time.

In the proposed rule, CMS suggests the use of Section O of the MDS to track minutes to ensure that restrictions on the use of the various modes of therapy are adhered to and to track when therapy services are provided or not provided. ASHA appreciates CMS’s attention to this issue,

June 25, 2018

Page 6

as raised by ASHA and other stakeholders, and we support the use of Section O of the MDS for this purpose. ASHA encourages CMS to consider how it will use data that demonstrates that therapy has not been provided, such as chart audits, to ensure that when therapy is not provided—despite receiving a therapy payment—the lack of therapy is appropriate based on the patient’s clinical condition as documented in the medical record. Evidence of stinting on therapy or providing maximum levels of concurrent or group therapy when not clinically indicated should receive appropriate scrutiny.

Thank you for the opportunity to provide comments on this proposed rule. ASHA remains committed to partnering with you to ensure revisions of the SNF PPS preserves access to SNF services, including speech-language pathology services, and minimize burden to the extent practicable. If you or your staff have any questions please contact Sarah Warren, MA, ASHA’s director for health care policy, Medicare, at [swarren@asha.org](mailto:swarren@asha.org).

Sincerely,

A handwritten signature in cursive script that reads "Elise Davis-McFarland".

Elise Davis-McFarland, PhD, CCC-SLP  
2018 ASHA President