ASHA
American
Speech-Language-Hearing
Association

June 9, 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-1785-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the hospital inpatient prospective payment system (IPPS) 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 members who are speech-language pathologists work in inpatient acute care hospitals and, as a result, have a vested interest in ensuring the regulatory and payment policies are appropriate for Medicare beneficiaries to have access to this critical level of care.

Health Equity Adjustment

ASHA supports the proposed health equity adjustments to inpatient hospitals 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 non-medical 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 as patients with fewer SDOH risk factors become more “attractive” to providers because 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 mostly healthy, uncomplicated patients who are 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*, leaving the most vulnerable patients without adequate access to care and exacerbating the health disparities common under fee-for-service.[1] ASHA appreciates the health equity adjustment methodology of incentivizing the care of dually eligible patients without penalizing inpatient hospitals 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.**

Proposed Changes to Severity Levels in Diagnosis Coding for SDOH

ASHA supports the proposal to change the severity level designation for SDOH diagnosis codes describing homelessness (Z59.0- series) from *non-complication or comorbidity (NonCC)* to *complication or comorbidity (CC)* for FY2024. Individuals who are experiencing housing insecurity are likely to demonstrate additional health and language needs compared to education matched controls.[2]

In a value-based payment system that measures performance and calculates provider payment based on cost and quality measures, it is essential to properly identify, and risk adjust for factors that will impact such measures that are outside of a provider's control. This includes universal screening for SDOH, proper documentation for easy access by the interprofessional collaborative care team in care planning, and correct coding to ensure fair payment to providers that accounts for both clinical characteristics and SDOH.

Proposed Updates to the Data Collection and Submission Requirements for the HCAHPS Survey Measure (CBE #0166)

ASHA is in favor of the proposed update to data collection and submission requirements for administration of the HCAHPS Survey measure under the Hospital Value-Based Purchasing (VBP) Program. Removing the requirement that only allowed the patient to respond to the survey and allowing a patient's proxy to respond to the survey could help capture data from individuals with communication disorders that otherwise could not be collected. For example, aphasia—an acquired communication disorder that impairs a person's ability to process language but does not affect intelligence—impacts nearly two million Americans a year.[3] Individuals with this language disorder can have difficulty with reading and writing, making it challenging to complete this patient reported outcome measure without assistance or using a proxy.

ASHA also applauds requiring hospitals to collect information about the language a patient speaks and requiring a Spanish translation of HCHAPS be administered to those who prefer

Spanish. According to a 2016 American Community Survey on language use in the United States, more than 65 million people use a language other than English and more than 1,000 different languages are spoken.[4] Improving language access increases the diversity of voices captured through the survey and is a step toward our shared goal of achieving greater health equity. **Therefore, ASHA recommends CMS expand the number or types of translations for HCHAPS as expeditiously as possible.**

Thank you for considering ASHA's comments. If you or your staff have any questions, please contact Rebecca Bowen, MA, CCC-SLP, PNAP, ASHA's director for value and innovation, at rbowen@asha.org.

Sincerely,

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

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[1] 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.
[2] Pluck G, Barajas BM, Hernandez-Rodriguez, J.L., Martínez, MA. Language ability and adult homelessness. Int J Lang Commun Disord. 2020 May;55(3):332-344. doi: 10.1111/1460-6984.12521. Epub 2020 Jan 11. PMID: 31925870.
[3] National Aphasia Association. (n.d.) Aphasia FAQs. https://www.aphasia.org/aphasia-faqs/.
[4] Gambino, C. (2016). *Inside the American Community Survey: 2016 language data overhaul.* https://www.census.gov/newsroom/blogs/random-samplings/2017/09/inside_the_american.html.