



ASHA
American
Speech-Language-Hearing
Association

May 27, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1767-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 2023 and Updates to the Inpatient Rehabilitation Facility Quality Reporting Program

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the inpatient rehabilitation facility prospective payment system proposed rule and focus on the request for information regarding overarching principles for measuring equity and health care quality disparities across CMS quality programs.

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 (SLPs) identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

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—while not unnecessarily increasing the reporting burden—and allowing for maintenance of existing measures.

ASHA acknowledges that statistical reliability and representative sampling are important but could 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 IRFs are encouraged or compelled to report measures that show differences between subgroups, and; 2) how these measures would be identified. If IRFs are allowed to select these measures, ASHA is concerned that IRFs 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 IRF 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 inpatient rehabilitation facility patient assessment instrument (IRF PAI), 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

As it relates to CMS's performance disparity decomposition, ASHA supports the Agency's approach as it will likely produce valuable data for analysis and minimize administrative burden on IRFs.

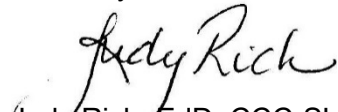
In terms of the Health Equity Summary Score (HESS), ASHA recommends CMS clarify that the score applies to the IRF, not individual clinicians within the IRF. Many clinicians understand this concept, but ambiguity has negative connotations for them because scores are often used by employers in a punitive fashion. Given the numerous factors outside an

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individual clinician's control in a facility setting, the score must be clearly attributed to the IRF.

Thank you for consideration of ASHA's comments. If you or your staff have questions, please contact Sarah Warren, ASHA's director for health care policy for Medicare at swarren@asha.org.

Sincerely,

A handwritten signature in black ink that reads "Judy Rich". The signature is written in a cursive style with a large, prominent initial "J".

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