ASHA
American
Speech-Language-Hearing
Association

June 1, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Attention: CMS-1737-P
P.O. Box 8016
Baltimore, MD 21244

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) for fiscal year (FY) 2021.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 211,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA supports the intent of the new case-mix adjustment methodology known as the Patient-Driven Payment Model (PDPM) since it pays for services based on the value of care, rather than the volume of care. Many SNFs have responded to PDPM in innovative ways and have embraced the value proposition. For example, some SNFs have developed robust interprofessional care planning teams and implemented multidisciplinary team completion of the minimum data set (MDS). However, ASHA members report that some SNFs have imposed administrative mandates that detract from the quality of care Medicare beneficiaries receive. Quality of care concerns that our members have reported include increases in aspiration pneumonia, falls, and hospital readmissions.[1] Additionally, ASHA fielded a survey in December 2019 that was completed by nearly 4,500 of our members working in skilled nursing facilities where a variety of administrative mandates were reported including:

- keeping patients on mechanically altered diets even when not clinically indicated;
- requirements to perform group and concurrent therapy when not clinically appropriate; and
- dictating the minutes of therapy provided even when the plan of care of the treating SLP indicated a greater need.

ASHA recognizes that the Centers for Medicare & Medicaid Services (CMS) had limited data upon which to make modifications to PDPM when moving forward with the statutorily mandated annual rulemaking process for FY 2021. However, ASHA appreciates that CMS reviewed the

[1] ASHA has developed a confidential feedback form where members can report both innovative and challenging implementation methodologies for PDPM. To date, the feedback form has been used 355 times.

available data related to changes in quality and program outlays and will make this data available to the public. Understanding whether or not quality of care has diminished under PDPM is critical to ensure that SNFs have not changed service delivery in response to PDPM in ways that potentially harm patients. Examples of quality metrics that could indicate diminished quality of care include increases in hospital readmissions, falls, and potentially avoidable health care complications like aspiration pneumonia.

ASHA recommends that CMS review and release data associated with the use of group, concurrent, and individual modes of therapy and therapy minutes in addition to program outlays and quality. ASHA recognizes that group therapy represents an important method of therapy delivery, but SLPs working in SNFs have reported to ASHA that supervisors and administrators have pressured them to provide group therapy even when it's not clinically appropriate for their individual patients. ASHA members regularly call or email the association seeking guidance on how to work with their supervisor or administrator who has told them they must do group therapy at least once a week or must provide at least 10% of therapy in groups for each patient, regardless of the patient's clinical presentation. According to the membership survey conducted by ASHA in December 2019, approximately 42% of the roughly 4500 respondents reported they were required to do group therapy against their clinical judgment and 35% indicated they were required to provide concurrent therapy against their clinical judgment.

ASHA also remains concerned that SNFs receive a therapy payment even when the facility provides little or no therapy to the patient. ASHA members also report that SNFs have implemented predictive analytic tools and other methods to overrule the clinical judgment of therapists and dictate how many minutes of therapy patients may receive. For example, these tools may dictate that patients with a particular diagnosis, such as a stroke, can only receive 20 minutes of speech-language pathology services a day, three times a week. CMS requires that each patient receives care based on their individual needs as documented in the plan of care. The use of predictive analytic tools may, in some instances, highlight a trend in which this requirement is not met.

Inappropriate utilization of group or concurrent therapy and/or significant reductions in therapy minutes based on financial incentives rather than clinical need may negatively impact quality and patient satisfaction as well as functional progress. ASHA remains committed to working with CMS and other stakeholders to identify ways to address potential abuses of the PDPM methodology. ASHA requests that CMS explore the need for a financial penalty for SNFs exceeding the 25% limitation on group and concurrent therapy in any systematic manner. ASHA also urges CMS to monitor and address instances when a SNF received a therapy payment without providing the therapy services.

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

Sincerely,

Theresa H. Rodgers, MA, CCC-SLP
2020 ASHA President