August 26, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services read
U.S. Department of Health and Human Services
ATTN: CMS–1803–P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write in response to the home health prospective payment system (HH PPS) proposed rule for calendar year (CY) 2025.

ASHA is the national professional, scientific, and credentialing association for 234,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students.

SLPs provide critical services to patients receiving home health and have a vested interest in ensuring that the payment system reflects the value of speech-language pathology services and supports access to care for Medicare beneficiaries. Following are ASHA's responses to the proposed rule.

III. Home Health (HH) Quality Reporting Program (QRP) Updates

Collection of Social Determinants of Health (SDOH) Data

ASHA supports the four new assessment data elements in the SDOH category that gather information on living situation, food availability, and utilities. We believe that robust data collection on patient demographics and SDOH enables more accurate analysis of health equity and improves the quality of care for all beneficiaries in the Medicare program. ASHA agrees that SDOH—or the nonmedical factors such as where people are born, live, learn, work, play, worship, and age—affect a wide range of health, functioning, and quality-of-life outcomes and risks. The identification, documentation, and intervention of such factors is essential for equitable, high-quality, holistic, patient-centered care. In line with CMS' goal to transition virtually all Medicare and Medicaid beneficiaries into accountable care relationships by 2030, we see the importance of including SDOH assessment items in the HH QRP to achieve greater health equity. We support the practice of early and holistic identification and treatment of upstream factors to improve downstream outcomes and costs.

ASHA applauds modifying the current transportation item so that it aligns with a transportation item collected on the Accountable Health Communities Health-Related Social Needs Screening Tool available to the Inpatient Psychiatric Facility Quality Reporting Program and Inpatient Quality Reporting Program.

We recognize that CMS has adopted these SDOH items in other post-acute care settings, including inpatient rehabilitation and skilled nursing. Alignment of reporting requirements across CMS quality programs will reduce administrative burden and facilitate clinical adoption of quality measure reporting. It also ensures beneficiaries get appropriate care regardless of practice setting.

Expanding Data Collection on Functional Status
ASHA supported the inclusion of a measure to capture function upon discharge in the calendar year 2024 rulemaking cycle. However, as currently structured, we believe the measure does not sufficiently capture all domains of function. ASHA encourages CMS to expand measure concepts to include determination of whether improvement or maintenance of communication, cognition, and swallowing function has occurred upon discharge from a home health episode of care. It is critically important to ensure Medicare beneficiaries are getting quality care and achieving the outcomes they require in all areas of function—including mobility, self-care, communication, cognition, and swallowing—to safely and effectively move on to the next level of care.

Expanded Home Health Value-Based Purchasing (HHVBP) Model

Request for Information on Future Performance Measure Concepts for the HHVBP
In response to the Request for Information (RFI) on Future Performance Measure Concepts HHVBP Model, ASHA underscores the vital importance of comprehensive functional outcome measures to accurately capture a patient's full range of functional status.

While mobility and self-care are critical elements of function, ASHA maintains our longstanding concern that Section GG of the Outcome and Assessment Information Set (OASIS) and the measures associated with function that CMS has adopted and proposed to date are insufficient to capture all associated functional domains, including communication, cognition, and swallowing. An incomplete assessment of holistic functions does not adequately capture the outcomes required for safety and independence.

Individuals with untreated and unaccommodated communication deficits are at risk for adverse outcomes—including poorer health, more chronic conditions, patient dissatisfaction, and increased health care costs.[1] Without treatment, communication disorders impact a patient's ability to follow directions; communicate medical needs with providers and caregivers; and alert safety services in case of an emergency.

Cognition impacts an individual's ability to manage medications, make reasonable personal safety decisions, and comply with home programs, which hinders the efficacy and efficiency of all other provided services. Untreated cognitive impairment is associated with potentially avoidable rehospitalization.[2]

Dysphagia—or difficulty swallowing—places patients at an elevated risk for malnutrition and dehydration, aspiration pneumonia, compromised general health, chronic lung disease, choking, and even death.[3]

Failure to capture holistic functional outcomes leaves home health beneficiaries vulnerable to myriad health risks and avoidable increased costs to Medicare. Our members have reported HHAs denying services to address communication, cognition, and dysphagia to cut costs as the impacts of these services are not explicitly captured in quality metrics. Appropriate upstream interventions to address the above issue will reduce unnecessary rehospitalizations and other downstream costs and improve the quality and outcomes of care for patients.

We remain committed to assisting CMS and post-acute care providers, including HHAs, to address all domains of function to include function measures complementing the existing cross-setting Discharge (DC) Function measure.

Health Equity
ASHA appreciates the health equity update and commitment to meaningful incorporation of health equity into the expanded HHVBP Model. The proposed Health Equity Adjustment (HEA), which incentivizes health care providers to serve patients with dual eligible status through the awarding of bonus points, addresses *cherry-picking* and *lemon-dropping*, which are unintended consequences of many value-based care models.

Cherry-picking refers to carefully selecting a caseload of mostly healthy, uncomplicated, and socially advantaged patients who are the most likely to have good outcomes with the least amount of intervention. There is a perverse incentive for providers to maximize their quality and financial rewards primarily by choosing only the ideal candidates for treatment.

Lemon-dropping is the opposite. Patients with chronic conditions, multiple comorbidities and disabilities, and those in underserved populations or communities with less access to preventive health care often require more services, increasing the total cost of care. Without an HEA, a health care provider's quality scores might be inappropriately reduced, or they may be incentivized to avoid patients to maintain higher quality scores and lower costs. As a result, these patients risk being dropped by providers and could have difficulty finding care without an HEA.

We support the proposed HEA to align incentives with CMS' goal of protecting complex patients with a high prevalence of health-related social needs to advance health equity. As proposed, "underserved population" is defined as those with dual eligibility status (DES). ASHA recommends CMS improve this proposal by incorporating an Area Deprivation Index (ADI), which is an important predictor of poor health outcomes even when adjusting for individual characteristics, because neighborhood or geography may play an even more important role in health than individual characteristics.[4,5]

VI. Home Health Conditions of Participation (CoP) Changes and Long-Term (LTC) Requirements for Acute Respiratory Illness Reporting

ASHA supports CMS' proposal to require LTC facilities to report data associated with COVID-19, the flu, and respiratory syncytial virus to the Centers for Disease Control. Sustained data collection and reporting of respiratory illnesses will help LTC facilities manage and develop policies around their infection control needs, ultimately protecting both patients and clinicians.

A. Home Health CoP Changes

2. Proposed Updates to the Home Health Agency CoPs to Require HHAs to Establish an Acceptance to Service Policy (§ 484.105(i))

In the proposed rule, CMS notes its concerns that Medicare beneficiaries referred to home health do not get the full range of services they need in a timely fashion. Many ASHA members and Medicare beneficiaries contact us to determine what obligations HHAs have to provide all the services—including speech-language pathology services—a patient needs. Too often we are told the agency does not have an SLP on staff and has not contracted with a private SLP or contract therapy company to ensure the patient has access to speech-language pathology services. Instead, the patient is told that speech-language pathology services cannot be provided due to staffing limitations or that they don't qualify for these

services despite it being ordered by the physician as part of establishing the home health episode for the patient.

These reports reinforce the need for additional oversight of HHAs in line with a new proposed condition of participation (CoP) for the development of an acceptance to service policy. If finalized, this policy would offer important protections to ensure a patient gets all medically necessary services when admitted to home health, and if at some point during the episode the HHA can no longer meet its obligations to the patient, the patient is discharged in a timely fashion. This would provide the patient the opportunity to get these services on an outpatient basis or through another agency if necessary.

While it may appear that this would create an additional administrative burden for HHAs, ASHA contends that, at a minimum, an agency is ethically bound to consider the needs of each individual patient and its capability for meeting those needs, including the presence—either through direct employment or a contractual relationship—of all clinical staff with the requisite skill sets needed by the patient. In other words, this would not create additional work—outside the public reporting of this information—because the decision-making process should already be occurring under the HHA's obligation to meet each patient's needs.

Under the proposal, the acceptance to service policy would be required to include, at a minimum, the following criteria related to the HHA's capacity to provide patient care: the anticipated needs of the referred prospective patient, the HHA's caseload and case mix, the HHA's staffing levels, and the skills and competencies of the HHA staff. It would have to be updated at least annually, and the policy must be applied to all patients regardless of payer source (e.g., Medicare, Medicaid, private insurance). **ASHA supports these proposals but requests that CMS make clear that if, at any point within a year, the HHA loses a clinical specialty, such as an SLP, that any gaps in coverage for required home health services be updated, incorporated into the policy, and publicly reported in a timely fashion.** In other words, when a change in the HHA's capacity to accept patients has occurred, relying on an annual update process is insufficient.

For example, if an HHA has one employed SLP and this person takes extended medical leave or resigns and speech-language pathology services cannot be provided as initially anticipated, this information needs to be updated on the website or other public resources in a timely fashion. In addition, ASHA recommends CMS require the HHA to proactively share this information with any patient or patient representative currently on its caseload based on the patient's identified contact preferences. Existing patients need to understand how service delivery might change—just as much as a prospective patient seeking to initiate care—in order to make informed choices regarding their care.

3.a. Requests for Information: RFI Regarding Rehabilitative Therapists Conducting the Initial and Comprehensive Assessment

CMS includes an RFI regarding whether therapists are qualified to open therapy and nursing home health cases. Currently, physical therapists and SLPs can only open therapy-only home health cases. ASHA believes that SLPs are capable of opening some, but not all, therapy and nursing cases. We agree that expanding their role in opening these cases might address the delays in care that CMS discusses in other sections of the proposed rule, specifically as it relates to the proposed new condition of participation for the development of an acceptance to service policy. We also recognize there are instances where a nurse conducts the initial assessment and misses signs that speech-language pathology

interventions are needed for the patient, jeopardizing access to care. ASHA supports the intent of the proposal. However, given the current working environment for many SLPs in this setting, where they are routinely forced to comply with inappropriate administrative mandates, ASHA believes CMS will need to use the existing CoPs to ensure HHAs appropriately utilize this discretion.

Specifically, as we have highlighted in previous comments to CMS and in other sections of this comment letter, some SLPs work in an environment where physician orders for speech-language pathology services are often altered or ignored. The plan of care of the SLP, which includes the frequency, intensity, and duration of services, is also sometimes ignored or altered. ASHA members all too frequently report administrative mandates to inappropriately pick up or discharge patients. Our members are concerned that if CMS expanded the ability of SLPs to open therapy and nursing home health cases, some HHAs would require them to conduct initial assessments that they may not be ethically or clinically equipped to conduct. When our members push back on administrative mandates, they are often told to do as they are told or find another job. Clinicians should never face such threats, which are hard to resist when employment is scarce where they live or when they have financial commitments that would make unemployment untenable.

As proposed, the acceptance to service policy will require the HHA to consider if its staff has the skills and competencies necessary to meet the anticipated needs of a referred patient. ASHA will outline the qualifications our members possess to open therapy and nursing home health cases; however, we firmly maintain that SLPs will need clear guardrails and expectations from CMS to govern the conduct of agencies. For example, we believe that if finalized, the proposed acceptance to service policy CoP could reinforce that an agency must not send an SLP to open a therapy and nursing case unless they are equipped with the skill set required to meet the individual needs of the patient.

Our members also report a wide variation in additional training provided by HHAs to their staff. While the current educational requirements for a master's of speech-language pathology sets the foundation for opening such cases, additional training specific to the requirements of the OASIS and clinical areas that need to be assessed must be provided to SLPs by the agency to ensure patients' needs are being met. SLPs do not typically assess, measure, or treat wounds, for example. But as part of the initial assessment process, SLPs could potentially provide basic information about the length or condition of a wound for the nurse or physical therapist to address if they are provided the correct level of training and support by their agency. Similarly, a physical therapist might need some additional training in assessing swallowing function to complete the initial assessment, as that is within the SLPs' scope of practice. Therefore, CMS would need to make clear that the HHA would need to coordinate with clinical staff, such as SLPs, to determine that it is reasonably certain that the clinician has the requisite training prior to sending that clinician to conduct an initial assessment. The HHA must be required to ensure that all clinicians eligible for opening a home health case have demonstrated clinical competency for all areas required as part of the initial assessment.

1. **What types of mentorships, preceptorship, or training do these disciplines have qualifying them to conduct the initial assessment and comprehensive assessment?**

   As noted in the proposed rule, SLPs are highly trained and educated. At a minimum, they must hold a master's degree, pass a standardized national exam, and complete a nine-month clinical fellowship under the mentorship of an SLP. Every state also requires

licensure for SLPs, ensuring that these clinical professionals adhere to a set of standards in order to practice. SLPs also have the option to obtain an ASHA Certificate of Clinical Competence (CCC), a nationally recognized professional credential that typically exceeds the academic and professional standards of state licensure. To maintain this certification, SLPs must engage in ongoing continuing education and demonstrate their maintenance of the CCC at least every three years.

Licensure and clinical education and training, combined with home health specific training provided by the HHA, prepares SLPs to open some therapy and nursing cases. In addition, ASHA's certification standards may further reinforce SLPs' ability to open therapy and nursing home health cases independently as outlined below.

The following excerpt is from ASHA's *2020 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology*.[6]

Standard IV: Knowledge Outcomes
Standard IV-A
The applicant must have demonstrated knowledge of statistics as well as the biological, physical, and social/behavioral sciences.
Implementation: Standalone coursework in (a) biological sciences, (b) chemistry or physics, (c) social/behavioral sciences, and (d) statistics that fulfill non-communication-sciences-and-disorders-specific university requirements. Refer to the list of acceptable coursework for further details and to the following for general guidance.

- *Biological sciences coursework provides knowledge in areas related to human or animal sciences (e.g., biology, human anatomy and physiology, neuroanatomy and neurophysiology, human genetics, veterinary science).*
- *Chemistry or physics coursework provides foundational knowledge in the areas below.*
  - *Chemistry: Substances and compounds composed of atoms and molecules and their structure, properties, and behavior, as well as the changes that occur during reactions with other compounds. This knowledge contributes to better acquisition and synthesis of the underlying processes of speech and hearing science.*
  - *Physics: Matter, energy, motion, and force. This knowledge contributes to better appreciation of the role of physics in everyday experiences and in today's society and technology.*
- *Social/behavioral sciences coursework provides knowledge in the analysis and investigation of human and animal behavior through controlled and naturalistic observation and disciplined scientific experimentation.*
- *Statistics coursework focuses on learning from data and measuring, controlling, and communicating uncertainty. It provides the navigation essential for controlling the course of scientific and societal advances.*

Standard IV-B
The applicant must have demonstrated knowledge of basic human communication and swallowing processes, including the appropriate biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases. The applicant must have demonstrated the ability to integrate information pertaining to normal and abnormal human development across the life span.

Standard IV-C
The applicant must have demonstrated knowledge of communication and swallowing disorders and differences, including the appropriate etiologies, characteristics, and anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates in the following areas:

- *Speech sound production, to encompass articulation, motor planning and execution, phonology, and accent modification*
- *Fluency and fluency disorders*
- *Voice and resonance, including respiration and phonation*
- *Receptive and expressive language, including phonology, morphology, syntax, semantics, pragmatics (language use and social aspects of communication), prelinguistic communication, paralinguistic communication (e.g., gestures, signs, body language), and literacy in speaking, listening, reading, and writing*
- *Hearing, including the impact on speech and language*
- *Swallowing/feeding, including (a) structure and function of orofacial myology and (b) oral, pharyngeal, laryngeal, pulmonary, esophageal, gastrointestinal, and related functions across the life span*
- *Cognitive aspects of communication, including attention, memory, sequencing, problem solving, and executive functioning*
- *Social aspects of communication, including challenging behavior, ineffective social skills, and lack of communication opportunities*
- *Augmentative and alternative communication modalities.*

Implementation: It is expected that coursework addressing the professional knowledge specified in this standard will occur primarily at the graduate level.

Standard V: Skills Outcomes
Standard V-B
The applicant must have completed a program of study that included experiences sufficient in breadth and depth to achieve the following skills outcomes:

1. *Evaluation*
   a. *Conduct screening and prevention procedures, including prevention activities.*
   b. *Collect case history information and integrate information from clients/patients, family, caregivers, teachers, and relevant others, including other professionals.*
   c. *Select and administer appropriate evaluation procedures, such as behavioral observations, nonstandardized and standardized tests, and instrumental procedures.*
   d. *Adapt evaluation procedures to meet the needs of individuals receiving services.*
   e. *Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention.*
   f. *Complete administrative and reporting functions necessary to support evaluation.*
   g. *Refer clients/patients for appropriate services.*

2. *Intervention*
   a. *Develop setting-appropriate intervention plans with measurable and achievable goals that meet clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process.*
   b. *Implement intervention plans that involve clients/patients and relevant others in the intervention process.*
   c. *Select or develop and use appropriate materials and instrumentation for prevention and intervention.*

d. *Measure and evaluate clients'/patients' performance and progress.*
e. *Modify intervention plans, strategies, materials, or instrumentation as appropriate to meet clients'/patients' needs.*
f. *Complete administrative and reporting functions necessary to support intervention.*
g. *Identify and refer clients/patients for services, as appropriate.*

3. *Interaction and Personal Qualities*
   a. *Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the individual(s) receiving services, family, caregivers, and relevant others.*
   b. *Manage the care of individuals receiving services to ensure an interprofessional, team-based collaborative practice.*
   c. *Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others.*
   d. *Adhere to the ASHA Code of Ethics and behave professionally.*

ASHA's ethical standards also require that SLPs provide services competently, meaning if the SLP were not able to complete the full assessment, they would not do so.

Standard VIII: Maintenance of Certification

Changed to add one hour of continuing education in ethics during the certification cycle. Specifically, the ASHA Code of Ethics (updated in 2023) requires ASHA members, certificate holders, and applicants to do the following:[7]

- ***Principle I, Rule A:*** *Individuals shall provide all clinical services and scientific activities competently.*
- ***Principle I, Rule B:*** *Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.*
- ***Principle II, Rule H:*** *Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.*

If an SLP did not believe they could open a therapy and nursing home health case based on these ethical standards, they would coordinate with their employer to ensure the right clinical professional is opening the case.

2. **How do HHAs currently assign staff to conduct the initial assessment and comprehensive assessment? Do HHAs implement specific skill and competency requirements?**

   ASHA does not have detailed knowledge about such policies but appreciates that CMS is seeking to gain this information. We believe it is critically important to understand how HHAs develop and implement these processes in order to meet patient needs and avoid inappropriate utilization of SLPs to open specific cases for which they may not be qualified.

3. **Do the education requirements for entry-level rehabilitative therapists provide them with the skills to perform both the initial assessment and comprehensive assessment? Is this consistent across all the therapy disciplines? How does this compare with entry-level education for nursing staff?**

   ASHA believes that any SLPs new to home health will likely need to have training to ensure they have the requisite skills necessary to open therapy and nursing cases. We

also maintain that it is the HHA's responsibility to fully assess and provide a clinician's training needs.

4. What, if any, potential education or skills gaps may exist for rehabilitative therapists in conducting the initial assessment and comprehensive assessment?

The initial assessment addresses a wide array of medical, nursing, and therapy needs. HHAs should be required to ensure any clinical staff opening these cases receive the requisite training to adequately complete all sections of the initial assessment.

3.b. Requests for Information: Plan of Care Development and Scope of Services Home Health Patients Receive

CMS also includes an RFI related to the development of plans of care for home health beneficiaries. It notes that they have gotten increased complaints from beneficiaries about the ability to access home health care and in many instances, when they are accepted, that the plan of care is modified by the agency despite the recommendations of the multidisciplinary care teams. Unfortunately, our members' experiences reinforce the negative findings CMS has heard from patients. Additionally, our understanding is that the Quality, Safety, and Oversight Group (QSOG) has determined that the lack of individualized plans of care in the home health sector is in the top 10 reasons for citation by state survey agencies. This is shocking given the range of facilities and CoPs state surveyors are accountable for reviewing. As a result, QSOG has engaged in extensive provider education and outreach to address this deficiency. ASHA appreciates that CMS is seeking feedback from stakeholders to address these concerns.

CMS states it is interested in feedback from stakeholders about how the services offered and business operations of the HHA may influence the development and implementation of care plans. It is also seeking additional information on how HHAs communicate with patients' ordering physicians and allowed practitioners regarding the frequency and duration of services. As CMS notes in the rule, therapy service delivery is down after implementation of the Patient-Driven Groupings Model (PDGM). ASHA has provided an extensive amount of member education to try to counteract the myths of PDGM implementation among clinicians—including SLPs and physicians—and Medicare beneficiaries. Patients and SLPs are often told that Medicare

- Will only pay for therapy if the patient falls into a clinical category that triggers a therapy payment, specifically neuro/stroke and musculoskeletal rehabilitation;
- Does not allow SLPs to treat patients with specific clinical conditions, such as cognitive impairments;
- Only covers a set number of visits, such as two visits a week for three weeks, and then the patient has to be discharged; or
- Sets a time limit (e.g., 30 minutes) for each visit.

Despite the efforts of CMS and organizations such as ASHA, these myths persist. And yet, we see payments to HHAs exceeding costs by an average of roughly 30% based on data provided by CMS in this proposed rule. While some of these myths persist because of a fundamentally flawed understanding of Medicare home health regulations, it is important to consider how profit motive is driving some of the reductions in service delivery.

One consequence of the HHA's failure to meet its obligations to deliver all medically necessary services, is the patient tries to get speech-language pathology services through a private practice SLP and either the patient or SLP calls ASHA to inquire if this is legal given

consolidated billing requirements for home health services. To ensure agencies are meeting their federal legal and regulatory obligations to provide the full range of services a patient might need, **ASHA urges CMS to review denials for consolidated billing in home health for therapy services to determine if more Medicare beneficiaries are seeking services outside of the HHA**.

1. **What factors influence an HHA's decision on what services to offer as part of its business model and how often do HHAs change the service mix?**

   ASHA believes there are several factors that influence an HHA's decision on what services to offer. For example, we hear there are substantial workforce shortages across clinical specialties and practice settings nationwide. According to our speech-language pathology member survey conducted in 2021, 35.5% of respondents stated that the number of job openings exceeded the number of applicants.[8] Staffing shortages obviously make it challenging, at best, to provide specific services.

   While we recognize a healthy bottom line is necessary to sustain a business, pay for supplies and equipment, and pay for staff salaries and benefits, it is also clear that profitability plays a role in determining whether to offer a particular service. Our members report that if an agency thinks it can "get by" with only having an occupational therapist (OT) provide cognitive treatment, it will do that to avoid paying two clinicians—the OT and SLP—to address a patient's cognitive needs. However, such decisions are made to the detriment of the patient and without an appropriate understanding of the distinct and critical roles both OTs and SLPs play in addressing patients' cognitive deficits.

   Our members report that case mix in post-acute care settings such as home health do not typically fluctuate wildly. For example, many HHAs make investments in staffing and equipment to meet the needs of specific patient populations or based on the unique needs of their communities. Frequent changes in case mix would make such investments unprofitable.

2. **What are the common reasons for an HHA to not accept a referral?**

   As noted above, workforce shortages might lead an agency to reject a referral. However, our members report that far too often, patients are added to a caseload even when the caseload is already extremely full, limiting the clinician's ability to adequately meet the needs of their patients. In other instances, the agency and its clinical staff might determine the patient is too acutely ill and should really be getting a higher level of service, such as skilled nursing.

   Alternatively, ASHA also hears of situations in which a particular patient is turned away because they can perform specific tasks, such as ambulating 50 feet, when in actuality, the range of services needed by the patient goes beyond ambulation or a specific clinical discipline or intervention. Such rejections are often based on the premise that the patient's needs are so minimal they are "unprofitable." A patient referral might also be rejected if the patient is seen as needing so many services that the profit margin would be dramatically reduced, or publicly reported quality data might be adversely impacted even if the HHA could or should accept the patient. In other instances, cases that could be treated on an outpatient basis are picked up by the agency because they could qualify for a relatively high payment with relatively low investment on the part of the agency or because the patient is low risk and has the potential to boost the publicly reported quality scores.

3. **How do physicians and allowed practitioners use their role in establishing and reviewing the plan of care to ensure patients are receiving the right mix, duration, and frequency of services to meet the measurable outcomes and goals identified by the HHA and the patient?**

   SLPs working in home health often reach out to us expressing concern that the plan of care they have developed for a patient is essentially rejected by the agency and is replaced by one dictated to the SLP by their employer. For example, the SLP evaluates a stroke patient and determines that the patient needs three visits a week for six weeks to address a variety of speech, swallowing, and cognitive impairments. However, through the use of proprietary utilization tools, such as predictive analytic models and electronic health record and billing systems, the HHA informs the SLP that the patient can receive two sessions a week for three weeks and then must be discharged from speech. In some instances, the agency even dictates the length of each visit. In many instances, the visit is restricted to 30 minutes; we've also frequently heard they can be limited to as little as 15 minutes.

   This places the SLP in a situation where they must advocate on the patient's behalf with their employer to secure the number of visits they believe the patient needs. Sometimes the employer essentially forces the SLP to modify the plan of care to conform to the plan the agency has deemed appropriate. This advocacy can take a variety of forms, with the SLP highlighting the evidence and research that supports the plan of care they have developed, encouraging the patient/caregiver to appeal with the agency and/or the Medicare program directly, and contacting the physician in an effort to secure the physician's help to convince the agency to implement the SLP's plan of care as written.

   ASHA also continues to be extremely concerned that physician/practitioner orders are routinely ignored. We have heard reports that, in some cases, the physician develops the order, and then the patient is rejected entirely, or the order is modified. Often, the patient is not able to push back against the HHA (e.g., they are too ill or have a cognitive impairment which precludes them from effectively advocating for themselves), and the physician is unaware that the order is wholly or partially unfulfilled. As such, ASHA has engaged both patient and physician organizations directly to dispel myths, call attention to the fact that patients are not getting what they and their physicians expect them to get, and empower patients and physicians to take proactive action to maintain access to care. **We also encourage CMS to consider if agencies should be required to follow up with physicians in some way when they have rejected a patient or altered the order or plan of care developed by the physician or multidisciplinary care team.** Reviewing medical record documentation, claims, and the OASIS data might help identify trends where patients are restricted in the frequency, intensity, and duration of services and where plans of care are not being individualized to patients' needs.

4. **To what extent do physicians rely on HHA clinician evaluations and reports in establishing the mix of services, service frequency, and service duration included in the plan of care?**

   ASHA members report that physicians do typically defer to therapists to develop the frequency, duration, and intensity of services. However, physicians usually are not aware of instances where the HHA rejects the clinical recommendations of the therapist. As a result, there is often additional work for SLPs to advocate with the multidisciplinary care team members—such as the physician—and the agency to try to secure these services for their patients. This issue has been so problematic that ASHA coordinated with the

American Physical Therapy Association and the American Occupational Therapy Association to develop resources for both patients and physicians about the importance of holding HHAs accountable for providing the services identified in the plan of care. Despite this outreach, the reports we get from SLPs working in home health indicate that the situation has not improved.

5. **What are the patient and caregiver experiences in receiving nursing, aide, and therapy services when under the care of an HHA?**

   ASHA is occasionally contacted by a patient or their caregiver about not getting the services that their physician has ordered or that the agency multidisciplinary care team has told them they should be getting. These patients tell us they are told Medicare doesn't cover these services because, for example, Medicare will only pay for therapy services if the patient falls into a PDGM clinical category that triggers a therapy payment. They ask us if they are allowed to see an SLP in private practice and, if so, if those services can be billed to Medicare or if they can pay out of pocket for these services. However, consolidated billing rules clearly preclude billing for these outpatient services. At the conclusion of these discussions, it's clear the patient or caregiver is frustrated. They feel they do not have options to get the care that they need and are overwhelmed at the amount of self-advocacy they would need to engage in to secure the benefits they are guaranteed under law and regulation.

6. **What additional evidence is available regarding negative outcomes or adverse events that may be attributable to the mix, duration, and service frequency provided by HHAs, including, but not limited to, avoidable hospitalizations?**

   CMS should consider if agencies are not meeting their obligation to provide individualized treatment services through the survey and certification process.

7. **In what ways can referring providers and HHAs improve the referral process?**

   CMS should consider how to establish a required feedback loop from the HHA to the ordering clinician when the patient is rejected entirely or when the order and/or plan of care is altered.

Thank you for considering our comments. If you have questions regarding ASHA's responses to the requests for information and or/updates to the conditions of participation, please contact Sarah Warren, MA, ASHA's director for health care policy for Medicare, at swarren@asha.org. For questions regarding the quality reporting program, value-based purchasing program, and health equity, please contact Rebecca Bowen, CCC-SLP, ASHA's director for health care policy for value and innovation, at rbowen@asha.org.

Sincerely,

Tena L. McNamara, AuD, CCC-A/SLP
2024 ASHA President

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[1] American Speech-Language-Hearing Association. (n.d.). *Better Health Starts with Effective Communication.* https://www.asha.org/practice/better-health-starts-with-effective-communication/
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