AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

July 5, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS 2328-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2328-P; Comments on Medicaid Program: Methods for Assuring Access to Covered Medicaid Services Proposed Rule (*Federal Register,* May 6, 2011)

Dear Dr. Berwick:

The American Speech-Language-Hearing Association (ASHA) is the professional, scientific, and credentialing association for 145,000 members and affiliates who are audiologists, speech-language pathologists, and speech, language, and hearing scientists. We appreciate the opportunity to comment on the Medicaid Program; Methods for Assuring Access to Covered Medicaid Services proposed rule.

ASHA applauds the efforts of CMS to assure that there is sufficient access to provision of quality care for Medicaid beneficiaries, as stated in the proposed rule. Further, ASHA supports the framework suggested by the Medicaid and CHIP Payment and Access Commission (MACPAC) which considers: enrollee needs; the availability of care and providers; and utilization of services. We would, however, like further clarification in selected areas, in order to strengthen the proposal and criteria noted. We are commenting on five issues in the proposed rule: 1) delivery systems, 2) application to management care organizations, 3) pricing, 4) Subpart B-Payment Methods: General Provisions, and 5) notification.

Delivery Systems

The purpose of the proposed rule is to create a standardized, transparent process and Section I, Background, notes multiple delivery system models. ASHA supports the multiple delivery system models, with the full component of care management team approaches available to Medicaid beneficiaries in the states. Of particular interest is the inclusion of telemedicine as an alternative system, with further expansion to include speech-language pathologists and audiologists among professional service providers. From *Telehealth in audiology: The need and potential to reach underserved communities,*[1] "Permanent hearing loss is a leading global health care burden, with one in 10 people affected to a mild or greater degree. A shortage of trained health care professionals and associated infrastructure and resource limitations mean that hearing health services are unavailable to the majority of the world population. Utilizing information and communication technology in hearing health care, or tele-audiology, combined

[1] Swanpoel, D., J. Clark, D. Koekemoer, et.al. *International Journal of Audiology* 2010 49:195-202

with automation offer unique opportunities for improved clinical care, widespread access to services, and more cost-effective and sustainable hearing health care." Further, as noted by ASHA,[2] "(f)rom an economic perspective, receiving services via telepractice eliminates the direct cost of travel and indirect costs of lost work productivity associated with travel time for clients and accompanying family members. Telepractice can increase work efficiency and productivity of clinicians by eliminating the need to travel great distances for home health care or to satellite clinics. Telepractice can also eliminate the need to cancel sessions due to poor weather conditions."

Application to Managed Care Organization (MCO) Payments

It is noted that the requirements for this rule apply to all Medicaid services paid under fee-for-service (FFS), however, according to the Kaiser Family Foundation[3] (February, 2010) over 70 percent of Medicaid enrollees are in some form of managed care, and over half of these in managed care organizations. The regulation developed as part of this rule should be applied to the access and payment for all Medicaid beneficiaries, and should not be so narrowly focused on the small minority for whom payment is fee-for-service. ASHA believes the value of measuring access to patient care in FFS settings should apply to a substantial percentage, and growing number, of Medicaid beneficiaries. That is, we recommend these requirements apply to MCOs as well as FFS plans.

Pricing

The regulation requires that the review must include financial changes, and among the options listed are the Medicare payment rates. Consideration should be given to a mechanism for selecting states that should adopt the Medicare Physician Fee Schedule (MPFS) or a percentage of the MPFS rates. We say this because rates need to reflect the costs of providing a service. The MPFS is a product of considerable research and experience for determining reasonable relative value units that can be converted into reasonable rates. This would also address the geographic variability among and within the states by using the geographic cost index.

Subpart B – Payment Methods: General Provisions

Section 447.203 specifies ways to measure access, but clarification needs to be provided as to measurements defining substandard access. There should be a standardized way to measure access and make it consistent across medical procedures. All the data elements suggested, including extent of knowledge that a service is covered, success in scheduling an appointment, transportation available to appointments, and limitations due to lack of English language proficiency, should all be captured, but parameters on expected levels should be stated to determine at what levels these measurements constitute substandard access.

Section 447.203(D)(2) states that all covered services should undergo a full review at least once every five years. The review should occur more frequently, and initially should be reviewed within the first year and then every three years following. The frequency of review will address several factors. For example, by collecting data on access as noted above, and determining substandard practice, the frequency of gathering this information will serve to monitor compliance with the

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[2] American Speech-Language-Hearing Association. (2005). *Speech-Language Pathologists Providing Clinical Services via Telepractice: Technical Report* [Technical Report]. Available from www.asha.org/policy.

[3] Kaiser Family Foundation, Medicaid and the Uninsured, *Medicaid and Managed Care: Key Data, Trends and Issues*, February 2010.

standards, and allow for adjustments and changes as needed. Also, the more frequent reviews will substantiate changes to reimbursement rates based on compliance with standards set.

Section 447.203(D)(4) states that there must be ongoing mechanisms for beneficiary input on access to care. ASHA supports adding providers to those able to provide input on access to care as well. While the information provided by the beneficiary, for example, ease of scheduling, knowledge of coverage, transportation to provider is critical, there are areas that the provider experiences that may be unknown to the beneficiary by virtue of the provider's unique knowledge of needed services, costs of service provision, and information about cancellations and rescheduling in terms of office management. Information from providers and beneficiaries would provide a complete picture of the success of the program.

Section 447.204(a)(2) states that while input from beneficiaries and affected stakeholders is solicited, we suggest that the State "must" maintain, rather than "should" maintain a record of the volume and nature of the response to such input to make them accountable. Requiring the maintenance of this information assures that sufficient data from all parties involved with providing and receiving the service is available.

Section 447.204(b) states that if CMS determines that service rates are modified without analysis (i.e., reflecting consideration of the information and procedure described), the agency "may" disapprove a proposed State plan amendment. ASHA supports a change to this language so that the agency "will" disapprove such amendment. As noted above, by making the action mandatory, the states will be accountable for the actions that are taken.

Notification

ASHA agrees that there should be adequate public notice for any changes in payment methodology rather than just for significant changes (Sec. 447.205(a)). ASHA supports both posting and notification of changes. Electronic notification should also be provided directly to State health care and medical associations when the State is considering a rate revision.

Thank you for the opportunity to present our comments regarding Medicaid access. Should you need further information, please contact Laurie Alban Havens, ASHA's director of Medicaid and private health plan advocacy, by phone at 301-206-5677 or by e-mails lalbanhavens@asha.org.

Sincerely,

Paul R. Rao, PhD, CCC, CPHQ, FACHE
2011 ASHA President