



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

September 7, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to comment on the Medicare Physician Fee Schedule proposed rule, which includes provisions associated with the Quality Payment Program for calendar year (CY) 2019.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

Our comments focus on the following areas:

1. Inclusion of Audiologists and Speech-Language Pathologists in MIPS
2. Additional MIPS Recommendations
3. Inclusion of Audiologists and Speech-Language Pathologists in Advanced Alternative Payment Models (A-APMs) and Other Payer Advanced Payment Models (APMs)
4. CY 2018 Exclusion of MIPS Eligible Clinicians Participating in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration
5. Eligibility of Audiologists and Speech-Language Pathologists to Bill for Proposed Communication Technology-Based Services
6. Elimination of the Functional Limitation Reporting (FLR) Requirements for Therapy Services
7. Acceptance of the Practice Expense Inputs and Work Relative Value Units (RVUs) for Speech-Language Pathology-Related Current Procedural Terminology (CPT) Codes

Inclusion of Audiologists and Speech-Language Pathologists in MIPS

CMS proposes to exclude audiologists and speech-language pathologists (SLPs) from MIPS for 2019 based on the limited number of measures—five for audiologists and three for SLPs—currently available to report. Through direct communication, ASHA has clarified CMS' rationale for the

proposal. While ASHA recognizes the six-measure standard CMS is using to evaluate participation of new specialties, ASHA notes Table 32 of the proposed rule where CMS maintains a measure applicability and validation (MAV) process by which clinicians from clinical specialties with less than six measures can participate in MIPS.

ASHA is committed to the inclusion of audiology and speech-language pathology services in MIPS. ASHA recognizes the importance of quality reporting, as well as MIPS participation, for demonstrating the value of audiology and speech-language pathology services. As incentives and penalties increase over time and opportunities to use “ramp up” flexibilities decrease, it is critical that CMS integrates additional clinical specialties into MIPS as soon as practical. Participation in MIPS signals to payers, advanced payment model (A-APM) conveners, and patients that our members are demonstrating the quality and value of their services. ASHA views MIPS, particularly the quality reporting element, as a valuable stepping-stone for inclusion in A-APMs and Other Payer APMs, as well as a mechanism for driving best practices within the professions.

ASHA understands that there are five measures available to audiologists and three measures available to SLPs for potential reporting if included as EPs in 2019. These measures are listed below for your reference.

Audiology Measure Set

Measure 101: Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls Measure

130: Documentation of Current Medications in the Medical Record

Measure 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure 226: Preventative Care & Screening: Tobacco Use: Screening & Cessation Intervention

Measure 261: Referral for Acute or Chronic Dizziness

Speech-Language Pathology Measure Set

Measure 130: Documentation of Current Medications in the Medical Record

Measure 131: Pain Assessment and Follow-Up

Measure 226: Preventative Care & Screening: Tobacco Use: Screening & Cessation Intervention

As noted above ASHA members could potentially participate in MIPS in 2019 through the MAV process that previously applied to audiology and speech-language pathology as well as many other specialties under the Physician Quality Reporting System (PQRS). Such a process is already employed by CMS to facilitate the participation of a few medical specialties that do not have six measures to report but are statutorily required to participate in the program.

If CMS finalizes its proposal to exclude audiologists and SLPs in 2019 because the professions do not have six measures approved for MIPS quality reporting, ASHA requests that CMS actively plan to include audiology and speech-language pathology for 2020. ASHA will work with CMS and measure owners to expand the number of measures our members will be eligible to report in 2020. ASHA’s goal is to support the most reasonable path forward for inclusion of its members in MIPS reporting. The 2020 path for including audiologist and SLPs in MIPS allows for the identification of additional claims-based measures to meet the six-measure standard as well as allowing time for provider education to facilitate successful participation. **ASHA reiterates its commitment to inclusion in the program by 2020 at the latest.**

ASHA’s National Center for Evidenced-Based Practice (NCEP) is developing a qualified clinical data registry and discipline specific quality measures that ASHA intends to submit to CMS for

approval. Until that effort is complete, ASHA is committed to identifying the most appropriate MIPS measures and engaging measure developers to add our CPT codes to the measure denominators. For example, ASHA intends to work with the developers for measure #131 (pain assessment and follow-up) for audiology and measure #182 (functional outcomes assessment) for speech-language pathology.

ASHA also requests the opportunity to discuss this process with CMS in more detail to ensure audiology and speech-language pathology are prepared for full inclusion in MIPS for 2020. To maintain the array of measures available for member reporting, ASHA urges CMS to maintain claims-based reporting for the various measures that can be reported by multiple specialties such as elder abuse, body mass index, and high blood pressure screenings and assessments.

Finally, in the rule there are three quality measures—historically reported by occupational therapists (OTs) under the PQRS—proposed for removal from the PT/OT Specialty Measure Set. This is outlined in Table B of Appendix 1 of the proposed rule. It appears these measures are still a part of MIPS but not for occupational therapy. Under PQRS, ASHA members reported two of these measures. The measures include measure #226 (preventative care and screening: tobacco use: screening and cessation intervention), and measure #134 (preventive care and screening: screening for depression and follow up plan). **ASHA requests that CMS maintain these measures for claims-based reporting.**

Additional MIPS Recommendations

CMS proposes to expand the low volume threshold criteria to include clinicians who perform 200 or fewer covered professional services. However, CMS does not clearly define a covered professional service. **ASHA supports defining the concept of a covered professional service as a single unit of a CPT code.**

In anticipation of ASHA members' inclusion in MIPS by 2020, ASHA has considered the impact of eliminating the resource use and promoting interoperability (PI) categories for non-physician EPs and reweighting the quality and clinical practice improvement activities (CPIA) categories. As a result, ASHA agrees that resource use and PI weights should be redistributed to quality and CPIAs, but ASHA does not agree that the quality category should be weighted at 85% and CPIAs at 15%. Instead, **ASHA supports CMS' alternate proposal to weigh quality at 70% and CPIAs at 30%.** The alternate proposal more closely follows the category weighting structure in the Medicare Access and CHIP Reauthorization Act (P.L. 114-010), and ASHA does not believe Congress intended to have any single category carry such significant weight.

Inclusion of Audiologists and Speech-Language Pathologists in A-APMs and Other Payer APMs

ASHA appreciates that audiologists and SLPs are able to participate in A-APMs and Other Payer APMs. However, ASHA has concerns about how the proposed requirements surrounding the use of certified electronic health record technology (CEHRT) could limit their ability to meaningfully participate in this transformative payment and delivery model. As Medicare continues its progression to APMs, it is essential that the APM requirements are designed to not only allow physicians but also non-physician professionals the maximum opportunity to participate. If one of the goals of CMS is to develop an APM framework that supports a health care system that puts patients first, then the system must be structured in a way that empowers patients to have access to and a choice of all

providers that are best suited to meet their unique health care needs. Ultimately, access to the right care at the right time is the goal of patient-centered care.

CMS proposes to raise the CEHRT use criterion for eligible clinicians from 50% to 75% in 2019 for A-APMs and in 2020 for Other Payer APMs. Therefore, APM entities will have to require that at least 75% of eligible clinicians to use CEHRT to document and communicate clinical care. CMS suggests that this proposed change aligns with the increased adoption of CEHRT among providers and suppliers. However, a major barrier to A-APM and Other Payer APM participation for audiologists and SLPs is the requirement that the APM entity uses CEHRT. Meaningful use requirements of EHRs are designed for prescribing providers and do not capture tasks performed by non-physician professionals, such as audiologists and SLPs, using EHR.

While ASHA supports the concept of CEHRT use, **ASHA recommends that a distinct CEHRT program is developed and/or funding is allocated for non-physician and non-prescribing professionals as soon as possible because audiologists and SLPs are eligible to participate in A-APMs and Other Payer APMs in 2019.** Otherwise, private practice audiologists and SLPs should be exempt from this requirement.

ASHA supports the joint CMS and Office of the National Coordinator for Health IT (ONC) initiative to make federal funding available at a 90% match rate for state expenditures. This initiative promotes health information exchange (HIE) for providers who are ineligible for meaningful use incentives under Medicaid to enhance communication with providers who are already eligible for support.¹ Under this initiative, funding can be used by ineligible providers for HIE start-up and onboarding, which could help eligible providers meet the criterion for electronically transmitting a summary of care record during a care transition between long-term care and post-acute care providers. The article states that by focusing resources on connectivity with long-term care and other post-acute-care providers, states can improve transitions for patients who move back and forth between acute and post-acute care, potentially reducing unnecessary hospital readmissions and resulting in a significant source of savings. However, although this funding is available, it is unlikely to be enough to effectively include all ineligible providers into HIE and/or to adopt CEHRT.

ASHA recommends that CMS and ONC consider expanding this initiative to ineligible providers under Medicare as well. Until this occurs, private practice audiologists and SLPs will be excluded from participation in an advanced APM or Other Payer APM. This is particularly important as CMS and other payers move to integrated care coordination. ASHA encourages CMS to work with professional societies in order to support an infrastructure that will allow full participation among the entire provider community.

CY 2018 Exclusion of MIPS Eligible Clinicians Participating in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

ASHA is pleased that CMS announced the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration that will test whether excluding MIPS eligible clinicians who participate in Medicare Advantage (MA) APMs from MIPS reporting will increase APM participation. This critical step advances the policy objective of creating more APMs and promoting the movement from fee-for-service to value. To encourage APM participation among all eligible clinicians, it is important that CMS afford equal credit to providers participating in MA value-based arrangements. Creating greater opportunities and incentives for A-APMs in MA will advance the Medicare delivery system for all seniors. **However, it is imperative that they are structured to**

allow meaningful participation by all eligible clinicians. For example, although CMS is proposing that demonstration participants must meet certain requirements to qualify for exclusion from MIPS (e.g., 2018 Medicare payment and/or patient thresholds), unlike traditional A-APM participants they are ineligible to receive a 5% bonus. In addition, CMS is only allowing individual clinicians to apply for the demonstration, which means that applications submitted at the organizational or group level will not be accepted.

Eligibility of Audiologists and Speech-Language Pathologists to Bill for Proposed Communication Technology-Based Services

Congress established narrow parameters for coverage of telehealth services and restricted reimbursement primarily to physicians in the Balanced Budget Act of 1997 (P.L. 105-33). In the proposed rule, CMS developed a new category of codes for communication technology-based services including virtual check-ins and the clinical evaluation of patient-submitted photos. These services are represented by Healthcare Common Procedural Coding System (HCPCS) codes GVC11 and GRAS1, respectively. The new codes were developed outside of the criteria and associated restrictions for telehealth. As such, the communication technology-based codes should apply to all Medicare-recognized providers, including audiologists and SLPs.

Examples of SLP services that could be represented by GRAS1 include reviewing videos and/or recordings of speech and language samples. Audiologists could perform this service by reviewing recorded audiograms. For virtual check-ins, an example of how a SLP would qualify to bill this service is by checking in with a patient after a planned break from services to go over progress and goals and decide if further assessment and treatment is warranted.

Elimination of the Functional Limitation Reporting (FLR) Requirements for Therapy Services

Since 2013, SLPs and other therapy providers have reported functional limitations on claims as a requirement of the Middle Class Tax Relief and Job Creation Act (MCTRJCA) (P.L. 112-96). As implemented by CMS, therapists would report the current status, projected goal, and severity associated with a patient's functional limitation any time an evaluation is performed, every 10th visit (which tracks to the progress report documentation requirements) and at discharge, when possible. This reporting requirement proved burdensome for therapists and yielded poor data. CMS did not standardize severity reporting and did not provide feedback to therapists. As a result, therapists saw FLR as an administrative mandate with no clear goal or utility.

ASHA supports the proposal to eliminate this reporting requirement in 2019 and thanks CMS for reducing the administrative burden on SLPs.

Acceptance of the Work Values for Speech-Language Pathology-Related Current Procedural Terminology (CPT) Codes

ASHA recognizes CMS' ongoing efforts to establish work and practice expense (PE) relative value units (RVUs) for new, revised, and potentially misvalued codes. **ASHA is pleased that CMS accepted the Health Care Professionals Advisory Committee (HCPAC) work RVU and PE recommendations for CPT codes 96105 (assessment of aphasia) and 96125 (standardized cognitive performance testing).** These codes were reviewed as part of the psychological and neuropsychological testing family of codes. ASHA looks forward to continuing our collaboration with CMS, the American Medical Association, and other specialty societies to ensure that services

September 7, 2018

Page 6

for Medicare beneficiaries with hearing and communication disorders are equitably valued through the Relative Value Update Scale Committee process.

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

Sincerely,

A handwritten signature in cursive script that reads "Elise Davis-McFarland".

Elise Davis-McFarland, PhD, CCC-SLP
2018 ASHA President

¹ Adler-Milstein, J. (2016, May 25). *A Creative Plan that Could Help Providers Ineligible for Meaningful Use Not Get Left Behind in the Paper World*. [Health Affairs Blog]. Retrieved from <http://healthaffairs.org/blog/2016/05/25/a-creative-plan-that-could-help-providers-ineligible-for-meaningful-use-not-get-left-behind-in-the-paper-world/>.