AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted to https://innovation.cms.gov/initiatives/direction/

November 19, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS Innovation Center New Direction Request for Information

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments regarding the request for information (RFI) on the new direction of the Center for Medicare & Medicaid Innovation (CMMI).

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

This letter includes ASHA's comments on the following focus areas outlined in the RFI:

- Physician Specialty Models
- Medicare Advantage Innovation Models
- State-Based and Local Innovation, including Medicaid-Focused Models
- Opportunities for Participation in Advanced Alternative Payment Models

Physician Specialty Models

While ASHA appreciates CMMI's efforts to move forward with delivery and payment reform that extends beyond primary care, we are concerned about the exclusion of services delivered by non-physician clinicians such as audiologists and speech-language pathologists (SLPs). In the RFI, CMMI seeks to increase the availability of alternative payment models (APMs) that engage independent practicing specialty physicians. By focusing solely on physician services, the RFI does not take into account the entire continuum of care or the value of interdisciplinary care teams. Since the goal of CMMI is to support a patient-centric delivery system, it is imperative that CMMI's efforts are structured appropriately to empower patients with a choice of all providers necessary to meet their unique health care needs.

ASHA believes that the services performed by audiologists and SLPs must be factored into the development of APMs, as our members often treat patients with complex chronic conditions.

Audiologists identify, evaluate, and treat clients with hearing, balance, and tinnitus disorders. Hearing impairments may be related to medical conditions such as diabetes, hypothyroidism, chronic renal disease, cardiovascular disease, and Alzheimer's, as well as ototoxic medications such as

aminoglycoside antibiotics, loop-inhibiting diuretics, certain cancer chemotherapeutics, and pain management medications. In addition, certain syndromes—including Reyes, Usher's, Waardenburg, and Treacher Collins—are linked to hearing loss. Audiology services include determining candidacy for and selection, fitting, programming, and verification and validation of hearing devices and cochlear implants, as well as audiologic habilitation and rehabilitation.

Speech-language pathologists evaluate and treat speech sound and motor speech disorders, stuttering, voice disorders, aphasia and other language impairment, cognitive disorders, social communication disorders, and swallowing (dysphagia) deficits. These impairments may be related to conditions such as traumatic brain injury, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis, epilepsy, cancers of the head and neck, stroke, cerebral palsy, multiple sclerosis, autism spectrum disorder, as well as other congenital and neurogenic conditions.

Delivery and payment reform initiatives must actively engage and include non-physician clinicians. **Therefore, ASHA requests that CMMI expand the scope of APMs from "Physician Specialty Models" to "Condition/Procedural Models" as the latter will more accurately capture the contributions of the entire care team.**

Medicare Advantage Innovation Models

The CMMI is interested in expanding the Medicare Advantage (MA) Value-Based Insurance Design (VBID) model to drive innovation, lower costs, and improve both quality and outcomes. Currently, the VBID model allows MA plans to offer supplemental benefits or reduced cost sharing in seven states to enrollees with diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), past stroke, hypertension, coronary artery disease (CAD), and/or mood disorders. In 2018, dementia and rheumatoid arthritis will be included as targeted conditions.

ASHA supports the inclusion of these conditions in the model, given their prevalence within the MA population and their potential for higher resource use. In fact, audiologists and SLPs are frequently involved in the care of patients with these diagnoses. For example, audiologists typically treat patients with stroke, hypertension, and CAD for balance/vestibular issues. It is also common for patients with diabetes to have hearing loss with tinnitus due to systemic causes or as a result of high doses of antibiotics that require toxicity monitoring. Speech-language pathologists provide swallowing and communication treatment for stroke, CAD, CHF, and hypertension patients, as these conditions can lead to disabling communication for the patient. Speech-language pathologists also provide swallowing treatment for dysphagia in patients with COPD and stroke.

ASHA also supports MA plans offering reduced cost sharing for providers identified as high value. **ASHA believes that the services provided by audiologists and SLPs are appropriate for reduced cost sharing because of their direct involvement in the care of patients with the targeted conditions.** For example, copays could be eliminated or reduced for audiologists and SLPs identified as high value providers, or for patients with past stroke or hypertension.

We also appreciate CMMI's interest in allowing additional flexibilities to MA plans for supplemental benefits, which increases patient choice, improves patient care, and reduces patient costs. Coverage for audiology and speech-language pathology services generally fall under the rehabilitation and habilitation benefit category. **Therefore, ASHA strongly supports MA plans covering additional rehabilitation, including telehealth, as a supplemental benefit under the VBID model.** We

specifically recommend providing additional medically necessary rehabilitation if the underlying MA plan includes arbitrary visit limits. ASHA also recommends that MA plans cover, as supplemental benefits, the full range of services and rehabilitative treatment within the recognized scope of audiologists.

State-Based and Local Innovation, including Medicaid-Focused Models

Audiologists and SLPs provide therapy services to Medicaid and Children's Health Insurance Program (CHIP) enrollees.[1] As CMMI explores approaches to move children and youth who are enrolled in Medicaid and CHIP to APMs, ASHA believes that the following concepts should be factored into any delivery and payment reform initiatives.

General Principles for Pediatric-Focused APMs

- **Separate financial model for pediatrics that accounts for the long-term investment opportunity and the thin margins for short-term investments[2]**
  As compared to adults, the trajectories for improved outcomes and lower costs for children are often long-term, with short-term savings less achievable. In pediatrics, it is important to show progress over time; not a definitive short-term outcome.

- **Care coordination and care transitions**
  It is important to adopt approaches that ensure proper referral patterns between the primary care physician and other treatment providers to support integrated service model concepts. While recent efforts on payment reform have advanced coordinated care models, much of health care delivery remains fragmented. This is particularly evident for complex, high-cost patients. Furthermore, there is a need to streamline the administrative burden for authorization, reauthorization, and the extension of services, if needed.

- **Ensuring access to providers through funding and reimbursement**
  Sufficient Medicaid reimbursement is necessary to achieve access to care. Medicaid payments should be based on the true costs of delivering care. ASHA opposes block granting proposals for Medicaid that would limit federal matching funds. Block granting and per capita caps based on federal poverty census data within states would have a negative effect on children, particularly in states where Medicaid has expanded and where optional populations are covered.

- **Remove access barriers and promote effective telehealth tools**
  Telehealth technologies may increase patient access to medical care and improve medical compliance, especially in remote or underserved areas. Regulatory barriers that inhibit the adoption of telehealth should be reduced. Barriers include reimbursement ineligibility, as well as variations and restrictions among state licensure rules, including unnecessary requirements for face-to-face evaluations.

  Audiologists and SLPs have long demonstrated the capability to provide effective care through telehealth technologies. In 2014, ASHA fielded a survey to its members who indicated expertise in telepractice.[3] According to the results, over half of the audiologists and speech-language pathologists indicated that they currently provide audiology or speech-language services via telepractice. In addition, 18 states and the District of Columbia have laws and regulations,

definitions, or policies related to the use of telepractice for audiologists and speech-language pathologists.

Telehealth venues include medical centers, rehabilitation hospitals, community health centers, outpatient clinics, universities, patients' homes, and residential health care facilities. There are no inherent limits as to where telehealth may be implemented as long as the services comply with national, state, institutional, and professional regulations and policies. Telehealth is being used in the assessment and treatment of a wide range of clinical disorders within the scope of practice for audiologists and SLPs.

Challenges in Existing Pediatric-Focused APMs

- **Accountable Care Organizations**
  Definitions and parameters for Medicaid Accountable Care Organizations (ACOs) vary from state-to-state. However, there appears to be common characteristics that promote patient-centered care and care coordination. According to an analysis conducted by Leavitt Partners on Medicaid ACOs, one area in which states need assistance with implementing ACOs is integrating long-term services and supports.[4] For ACOs to become more meaningful from a patient and cost-saving perspective, states will need to consider implementing post-acute services, long-term services, and supports. These services are critical in order to provide comprehensive episodes of care. If states can more effectively incorporate post-acute and long-term services and supports into their ACOs, then they could potentially enhance chronic disease management, reduce unnecessary emergency room visits, develop more efficient care transitions, and facilitate the proactive diagnosis and prevention of post-discharge conditions. Other areas in which states need assistance are (a) understanding how to deploy population health analytics to improve care and (b) integrating behavioral health for children

- **Patient-Centered Medical Homes**
  Currently, 26 states have Medicaid Patient-Centered Medical Homes (PCMH) initiatives underway. Under this model, patient treatment is coordinated through the primary care physician to ensure patients receive care by employing care coordination and enhanced communication. While the PCMH concept is commendable, depending on how primary care physicians implement PCMH policies and processes, the model can have the unintended consequence of limiting patients' access to care. ASHA is aware that pediatricians who participate in Arkansas' Medicaid PCMH program have elected to modify operational processes by focusing on therapy and behavioral health. Specifically, the clinic requires newly referred therapy patients to choose one therapy provider for their initial evaluation, and a different therapy provider for their therapy services. The goal of this process is to adopt a "checks and balances" approach for patients so that the evaluation is independent of subsequent therapy services. Unfortunately, this requirement has created a barrier to therapy services in instances where access to participating Medicaid therapy providers is limited, particularly in rural areas. In addition, it is problematic for ensuring the most effective clinical treatment of patients.

Opportunities for Participation in Advanced Alternative Payment Models

The CMMI seeks feedback on ways to increase opportunities for eligible clinicians to participate in APMs under the Quality Payment Program. ASHA appreciates that CMMI wishes to be more responsive to eligible clinicians and their patients. A major barrier to Advanced APM participation

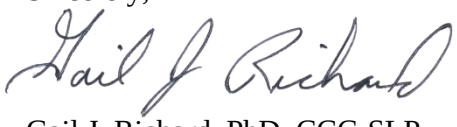
for audiologists and SLPs is the requirement that the APM uses current certified electronic health record technology (CEHRT) requirements without consideration of their participation within system/facility electronic health records. The current meaningful use requirements of electronic health records are designed for prescribing providers. As such, they do not capture tasks performed by non-physician clinicians, such as audiologists and SLPs. **While ASHA supports the concept of CEHRT use, we strongly recommend that a distinct CEHRT program be developed and funding allocated for non-physician and non-prescribing professionals as soon as possible. Without financial support and additional data elements within the scope of practice of our members, private practice audiologists and SLPs should be exempt from this requirement.** Additionally, supplemental funding made available for physicians should also be available to offset the costs of the system for non-physician clinicians.

In closing, please consider the following summary points:

- Interprofessional practice is necessary and should be encouraged by CMMI in future APM development to empower patients with the choice of all providers that are best suited to meet their unique health care needs.
- Given the direct role of audiologists and SLPs in treating Medicare and Medicaid enrollees with complex chronic conditions (e.g., stroke, autism spectrum disorder) that have a high prevalence and/or are high cost, their services are appropriate for inclusion in future CMMI models.
- The CMMI should develop a state-by-state clearinghouse to help providers identify and participate in local APMs.
- Technical and financial support must be provided to support EHR adoption in order to engage non-physician clinicians in Advanced APMs.

Thank you for the opportunity to provide comments on CMMI new direction RFI. If you or your staff have any questions, please contact Daneen G. Sekoni, MHSA, ASHA's director of health reform analysis and advocacy, at dsekoni@asha.org.

Sincerely,



Gail J. Richard, PhD, CCC-SLP
2017 ASHA President

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[1] American Speech-Language-Hearing Association. (n.d.). *Speech, Language, and Hearing Services for Children: A Smart Investment*. Retrieved from http://www.asha.org/uploadedFiles/Speech-Language-Hearing-Services-for-Children.pdf.

[2] Perrin, JM, Zimmerman E, Hertz A, et al. (2017). *Pediatric Accountable Care Organizations: Insight from Early Adopters*. *Pediatrics*. *2017*; 139(2):e20161840.

[3] American Speech-Language hearing Association. (2014). *2014 SIG 18 Telepractice Services Survey Results*. Retrieved from http://www.asha.org/uploadedFiles/ASHA/Practice_Portal/Professional_Issues/Telepractice/SIG-18-Telepractice-Services-Survey-Results-by-Profession.pdf

[4] Leavitt Partners. (2015). *The Rise and Future of Medicaid ACOs: themes, trends and takeaways*. Retrieved from http://leavittpartners.com/2015/09/the-rise-and-future-of-medicaid-acos-2/.