



June 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments on the proposed rule entitled "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)" that was published on May 3, 2023.

ASHA is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiology treatment, including hearing aids. Speech-language pathologists (SLPs) identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

ASHA values CMS's commitment to improving access to care for those beneficiaries enrolled in Medicaid managed care programs. CMS incorporated many suggestions offered in response to the "Request for Information: Access to Coverage and Care in Medicaid and CHIP" from April 2022, including some of those from ASHA's response to that request for information (RFI).¹

Enrollee Experience Surveys

We appreciate that CMS is gathering feedback from Medicaid enrollees about their experiences receiving health services through the Medicaid program and agree that it will provide valuable insight into program offerings. This feedback will serve multiple purposes by allowing a reporting structure for beneficiary input and the opportunity for managed care plans and states to identify access problems, particularly if the results are stratified by key demographics, to see where there are gaps in available services. As referenced in the proposed rule, ensuring accessible survey forms in a variety of formats is essential to ensure participation from a truly representative sample of the population. We recommend that future CMS guidance suggest oversampling or finding other mechanisms to ensure robust participation from people with disabilities, people with limited English proficiency, and other marginalized groups who are more likely to face access barriers.

The true utility of the information gathered will be the changes that plans make as a result of reviewing the enrollee feedback. A survey is only as useful as the programmatic changes it compels. We understand that with this proposed rule, CMS is supplying managed care plans with a variety of tools for information gathering to make informed changes to their networks and improve the quality of programs, and we are optimistic that this new information will assist them in doing so. ASHA also strongly supports the requirement that states post the results from these annual surveys on their centralized website as part of the Managed Care Annual Report.

Additionally, ASHA recommends that CMS require states to survey providers as part of their annual surveying process. CMS recognizes the value of information that enrolled providers can share as they have encouraged states to survey them; however, CMS is not mandating state Medicaid programs to survey providers at this time. Mandating that states conduct a provider survey will offer further perspective to states and managed care plans about network adequacy from those who are delivering the services. Providers can offer valuable stakeholder insight into challenges that beneficiaries face when navigating their health benefits and improvements that can be made to the Medicaid program writ large. Providers are often the frontline for questions about enrollees' Medicaid benefits and parameters; therefore, obtaining provider feedback is essential for programmatic success.

To understand why provider input is essential, we highly encourage CMS to consider the data gathered by ASHA's annual member payment survey.² The results revealed many issues with Medicaid fee-for-service and Medicaid managed care programs. Within the last two years, 26.4% of those surveyed reported decreases in Medicaid or managed care plan payment rates in their state; 13.2% restricted the number of patients seen from Medicaid or its managed care plans; and 11.7% had stopped treating patients from Medicaid or its managed care plans altogether. The survey comments universally cited challenges like low reimbursement rates, prior authorization difficulties, and long response times for assistance from the managed care plan among many others. ASHA urges CMS to take this important opportunity to compel states to listen to the professionals who are providing critical services for their beneficiaries.

Appointment Wait Time Standards

Thank you for carefully evaluating the responses to the April 2022 RFI about access to Medicaid services and taking the feedback of so many stakeholders who suggested adding additional quantitative network adequacy standards. ASHA appreciates that this proposed rule establishes wait time standards for outpatient mental health and substance use disorders (SUD)—adult and pediatric; primary care—adult and pediatric; obstetrics and gynecology (OB/GYN); and an additional type of service determined by the state. We agree that wait time standards will be a valuable metric to determine access if implemented appropriately by the plan. However, ASHA has several concerns about the current requirements of the wait time standards themselves, and the inherent limitations of focusing solely on the four types of services to which appointment wait time standards are applied in this proposed rule.

A significant portion of ASHA's members are Medicaid providers across a variety of settings including schools, hospitals, skilled nursing facilities, and outpatient clinics. Our providers

serve the entire lifespan of Medicaid beneficiaries from newborns to older adults. Because so many of our members are Medicaid enrolled providers, we routinely hear about the challenges and triumphs of working within this program. Many of our Medicaid enrolled providers have extensive patient waiting lists for various reasons, but especially due to low specialty provider enrollment in Medicaid. There are simply not enough audiologists and SLPs enrolled to meet beneficiary demand for services in numerous areas of the country. These concerns are not unique to audiologists and SLPs; overall, specialty care is difficult to access for Medicaid beneficiaries as CMS acknowledged in the proposed rule. ASHA asserts that the onus should be on the Medicaid managed care programs to ensure enough providers are in network to make the wait time standards achievable for the currently enrolled providers. If the plans operate under a “minimum providers necessary” approach for meeting their network adequacy requirements, providers will not be able to accommodate wait time standards that are being implemented and are essential for beneficiaries to get the care they need. ASHA has surveyed enrolled providers who have indicated that they have or will likely leave the program if they are expected to accommodate another administrative burden. Implementing wait time standards without adding more providers to the network creates another challenge for current providers to meet.

Managed care plans can incentivize providers to join and remain in network with Medicaid plans by increasing payment rates to levels that support the true value of the services and time that providers expend. **ASHA urges CMS to compel state Medicaid programs—to the extent legally permissible—to require their contracted managed care plan partners to reimburse at rates no less than those afforded by Medicare.** While Medicare rates still do not adequately account for all costs and services provided by audiologists and SLPs, some Medicaid managed care plans pay providers a small fraction of the Medicare rate.

For example, Ohio’s fee-for-service payment rate for up to one hour of speech therapy—billed under Current Procedural Terminology (CPT®) code 92507—is \$37.³ Medicare pays more than double that rate for the same code.⁴ As frequently happens, managed care plans have the flexibility to offer rates even lower than that of the Medicaid fee-for-service fee schedule; however, providers have little leverage to bargain with them. As a result, providers often leave the program, severely limit their Medicaid patient load, or never join to begin with because these prohibitively low rates are unsustainable for their practices.

Payment rates undoubtedly affect provider participation and can directly impact patient access to care. Higher provider payment rates are associated with higher rates of accepting new Medicaid patients.⁵ While ASHA understands that states have considerable flexibility in determining their rates for providers, following Medicare’s annual fee schedule—at a minimum—should be a recommended best practice.

The proposed rule indicates that the four services chosen to have wait time standards were selected because they are indicators of core population health. While population health is one metric to consider, Medicaid patients also deserve equitable access to specialty care, which CMS has recognized as essential to improved quality of care and outcomes.⁶ Since CMS has the regulatory authority to compel appointment wait time standards, ASHA suggests utilizing that ability to create the most robust network of providers possible,

regardless of provider type. Although we understand that CMS may be taking a conservative approach to applying wait time standards by selecting only four types of services, now is the time to ensure that access is as broad as possible.

ASHA recommends that CMS broaden the appointment wait time standard across all types of services to Medicaid enrollees, but especially to specialty providers like audiologists and SLPs. The proposed rule itself cites a 3.3-fold lower likelihood of successfully scheduling an appointment with a specialty provider when compared with private insurance. In that same study, CMS shared that primary care and OB/GYN services already have some of the highest acceptance rates for Medicaid. In addition, putting the onus on managed care plans to create robust networks to satisfy the appointment wait time standard requirements and accommodate the needs of beneficiaries across all provider types can help increase access to care for all beneficiaries.

Secret Shopper Surveys

ASHA appreciates that CMS is proposing to require states to use independent entities to conduct annual secret shopper surveys of 1) managed care plan compliance with appointment wait time standards and 2) the accuracy of data presented in electronic provider directories. These surveys will provide valuable information to plans, as well as the public, to give greater clarity on the real composition of provider networks. “Ghost networks”—or those plan network directories that list many in-network providers who are no longer enrolled, have moved, or have gone out of business—serve to disrupt and limit access to health care.⁷ In addition, most care is concentrated in a small percentage of providers who are actually delivering the services, even within those practices that are still enrolled.⁸

Although we see value in surveys done by independently contracted entities, **ASHA recommends that CMS require the surveys to be completed by entities who do not reveal themselves as secret shoppers.** Revealed caller surveys run the serious risk of inflating the true availability of in-network providers. For example, if the person answering the call knows the provider’s availability is being reported to CMS, they may not be truthful in the wait time that the average new patient can expect. We understand that—as a uniform business practice—some offices may not schedule an appointment unless a caller provides identifying information and potentially their insurance information. Those types of situations may obscure the results of the survey. However, stratifying the data collected from those offices would afford an extra layer of anonymity and accuracy to the rest of the survey, which could help reveal the true availability of providers who are in network.

ASHA agrees that the four elements of the survey that address the data presented in electronic provider directories—the active network status, the provider’s street address, the provider’s telephone number, and their status as accepting new Medicaid enrollees—are essential pieces of information in assessing the true availability of in-network providers. We also agree that appointments via telehealth should only be counted toward compliance with wait time standards if the provider offers in-person appointments in the same timeframe. ASHA affirms that telehealth is a valuable service delivery method for many patients; however, its application should be based on individualized patient needs and should not be considered an across-the-board replacement for in-person appointments.⁹

CMS has chosen the same four provider types for which this survey standard will be enforced, citing that these service providers have the highest utilization in many Medicaid managed care programs. However, ASHA submits that other providers have lower utilization because access to specialists remains very difficult for Medicaid patients, and that **CMS should collect secret shopper survey data across all service providers in the Medicaid program.** Such survey data may be even more helpful for specialty providers, since people generally have greater difficulty getting appointments with them. **ASHA also recommends that CMS consider requiring that the state's option for a fourth provider type must be a specialist provider type, such as an audiologist or SLP.**

In terms of reporting requirements, we appreciate the proposed timeframe for sharing results publicly and agree with the suggestion that the state and managed care entity should receive the report at the same time in order to remedy any access issues. ASHA also supports the proposal that this information should be reported publicly and posted on the state's website.

Assurances of Adequate Capacity and Services

As CMS indicates in this proposed rule, the link between higher acceptance of Medicaid insurance and higher payment rates for providers cannot be underscored enough. ASHA strongly supports the proposal that managed care plans must submit a provider payment analysis to the state and publish it on the state's website, including providing comparable rate data with Medicare or Medicaid fee-for-service rates if Medicare rates do not exist for a particular set of codes (e.g., certain long-term services and supports). Both the rate analysis itself and the public reporting could help inform stakeholders of the gaps in access and encourage managed care plans to make changes to their rates or other factors to attract a more robust network of providers. We also agree with the possible remedies that CMS enumerates, including support for interstate provider licensing compacts like ASHA's Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC), increasing provider payment rates, improving credentialing processes and timelines, claims processing, and prior authorization procedures, among others listed.¹⁰

In addition, while we strongly support the new requirement for states to submit remedy plans to improve access, we respectfully question the length of time required for true remedy. In this proposal, CMS suggests that plans have 12 months to implement actions to address the identified issue(s) and improve access to services. If plans have 12 months to implement, while providing quarterly updates as a check-in procedure, the proposal of granting an additional 12 months after that point would seem to allow plans to stretch their remedy plan to be finalized after at least two years. With as many access issues that have already been cited, allowing for two years to remedy a specific problem with multiple progress report opportunities would be too long for beneficiaries to see the benefits. Unless an extreme scenario occurs, ASHA finds it difficult to imagine a situation in which one year would be insufficient to remedy access issues.

Transparency

ASHA strongly supports efforts to increase transparency by requiring states to shift to one-stop centralized websites for posting information related to managed care plans. Currently, there are significant limitations seen on the websites of both state Medicaid agencies and

their managed care plan counterparts. One study from the Georgetown University Health Policy Institute's Center for Children and Families showed basic required information was often missing, citing that not one of the 13 states they reviewed posted managed care specific Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening metrics and not one of the state Medicaid agency websites posted all of the minimum data elements required by federal regulations.¹¹ With such wide variation in website performance and design, this required improvement for the 13 listed metrics would be incredibly valuable. Requiring direct links from the state Medicaid website to the appropriate correlate on the managed care plan's site is especially essential.

Thank you for your consideration of our recommendations. If you or your staff have questions, please contact Caroline Bergner, ASHA's director of health care policy for Medicaid, at cbergner@asha.org.

Sincerely,



Robert M. Augustine, PhD, CCC-SLP
2023 ASHA President

¹ American Speech-Language-Hearing Association. (2022 April 15). ASHA Comments to CMS on Medicaid Request for Information Coverage and Access. <https://www.asha.org/siteassets/advocacy/comments/asha-comments-to-cms-on-medicaid-ffi-coverage-and-access-041522.pdf>.

² American Speech-Language-Hearing Association. (2023 April). ASHA Member Survey, *Insurance Payment Reductions*.

³ Ohio Department of Medicaid. (n.d.). Fee Schedule & Rates. <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

⁴ American Speech-Language-Hearing Association. (2022 Nov 18). 2023 Medicare Fee Schedule for Speech-Language Pathologists. <https://www.asha.org/siteassets/reimbursement/2023-medicare-fee-schedule-for-slps.pdf>.

⁵ Holgash, K., Heberlein, M. (2019 Apr 10). *Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/forefront.20190401.678690/full/>.

⁶ Centers for Medicare & Medicaid Services. (2023 Jan 5). *HHS Expands Access to Essential Specialty Care for Millions of Medicaid and CHIP Beneficiaries*. <https://www.asha.org/siteassets/reimbursement/2023-medicare-fee-schedule-for-slps.pdf>.

⁷ Burman A., *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 Yale L. & Pol'y Rev. 78(2021); Burman A & Haeder S., *Without a Dedicated Enforcement Mechanism, New Federal Protections Are Unlikely to Improve Provider Directory Accuracy*, Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20211102.706419/full/>.

⁸ Ludomirsky, A., Schpero, W., Wallace, J., Lollo, A., Benheim, S., Ross, J., Ndumele, C. (2022 May). *In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians*. Health Affairs. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01747>.

⁹ American Speech-Language-Hearing Association. (n.d.). Telehealth Improves Patient Access to Care [Data Fact Sheet]. <https://www.asha.org/siteassets/advocacy/telepractice-data-fact-sheet.pdf>.

¹⁰ American Speech-Language-Hearing Association. (n.d.) Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC). <https://www.asha.org/advocacy/state/audiology-and-speech-language-pathology-interstate-compact/>.

¹¹ Georgetown University Health Policy Institute: Center for Children and Families. (2021 Sept). Transparency in Medicaid Managed Care: Findings from a 13- State Scan. <https://www.asha.org/siteassets/advocacy/telepractice-data-fact-sheet.pdf>.