



April 15, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: Request for Information: Access to Coverage and Care in Medicaid & CHIP

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Request for Information: Access to Coverage and Care in Medicaid & CHIP that was released on February 17, 2022.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 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 identify, assess, and treat speech, language, and swallowing disorders.

This letter addresses many of the objectives covered in the Request for Information (RFI).

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

- 1. What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.***

Given the likelihood that the federal public health emergency (PHE) will end soon, the Centers for Medicare & Medicaid Services (CMS) is at a critical turning point to support eligibility determination and enrollment in the Medicaid program. There were 14.6 million people enrolled in Medicaid between February 2020 and November 2021, representing a 20.5% increase in the program's beneficiaries.¹ These individuals will have varying coverage after the PHE ends and, because all states will resume redetermination in the 12 months following the end of the PHE, beneficiaries may experience changes or lapses in coverage soon.

ASHA appreciates the comprehensive PHE winddown plan CMS is undertaking with state Medicaid programs.² Because of the change in Medicaid eligibility that will result from this winddown, and because of historical churn that beneficiaries often experience as part of their

enrollment in this program, ASHA recommends that CMS consider a national and state-specific campaign to identify individuals who are potentially eligible for Medicaid services.³ There are vast differences that exist in eligibility communication policies between states and, due to a variety of factors, beneficiaries do not always know they are eligible for Medicaid services. Uninsured people most often have limited income, therefore, when they do need health care, they often cannot afford it, which leaves their health care providers uncompensated.⁴ Increasing enrollment for eligible individuals limits uncompensated care and benefits everyone.

By collaborating across agencies, CMS could obtain information from federal tax returns to identify possible beneficiaries based on income. This would standardize base financial criteria for eligibility at the federal level. Using a similar approach to the communications plan used for the PHE winddown, CMS could design a program for states to reach out to potentially eligible individuals using the information gathered from federal tax returns.⁵

This state-based communication would help ensure that Medicaid eligible people without coverage know they have this option available to them and would help reduce extraneous and unnecessary costs for eligible uninsured individuals who need health care. At its core, Medicaid remains an entitlement program and eligible individuals have rights to medically necessary health services.⁶ Connecting Medicaid eligibility to tax information and communicating that eligibility should be a baseline approach to protecting rights.

2. What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

State Medicaid eligibility systems need to be upgraded with interoperability and automation in mind. The technology and systems used vary widely between states, which slows down eligibility notifications, review of applications, and beneficiary enrollment processes. During the pandemic, Americans saw these difficulties up close as Medicaid enrollment swelled, and Americans were joining the program in record numbers. Using systems between states that are interoperable is essential to ensuring timely processing of beneficiaries who have moved to a new state or for data comparison by CMS.

ASHA recommends that CMS and states work to increase the number of renewals and redeterminations completed electronically to rely less on printed paperwork. Medicaid beneficiaries often experience housing instability, therefore, relying primarily on printed mail to reach beneficiaries who may change mailing addresses or experience homelessness can cause unnecessary gaps in health care coverage.⁷ Focusing on electronic renewals and redeterminations may help reach eligible beneficiaries without relying on a physical address.

In conclusion, state Medicaid agency staff would benefit from CMS providing nationally standardized education. ASHA recommends training that would include topics such as: Medicaid's state and federal requirements, structure, and differences; the value of compassionate and respectful communication with beneficiaries in various life circumstances; and the importance of timely and culturally responsive communication to those seeking assistance. Beneficiaries and providers alike receive information from state Medicaid agency hotlines that is often inconsistent from one call to the next. Nationally standardized education would help ensure uniform and correct information distribution.

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

- 1. What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?**

Network adequacy standards vary tremendously between state Medicaid programs and, while ASHA recognizes the complexities, maintaining more comprehensive federal standards for Medicaid managed care programs would ensure that states and their managed care partners maintain appropriate access to services. Beneficiaries have a right to a clear understanding of how they can access the care to which they are entitled upon enrollment in a particular health plan.

Clinicians, including audiologists and speech-language pathologists, who are applying to become Medicaid providers often receive enrollment denials because individual plans choose to establish narrow networks. Plans can also state that they have an adequate number of providers within a geographic area even, but that could be inaccurate based on the volume and variation of beneficiary needs. ASHA members report being turned away from allegedly full networks even when they are routinely contacted by Medicaid beneficiaries who cannot access an in-network provider for many months.

For example, to contract with select Coordinated Care Organizations (CCO) (which function like local Medicaid managed care plans) in Oregon's Medicaid program, NorthWest Rehab Alliance, therapy providers must pay \$2,000 for membership per year to enroll.^{8,9} When confronted with this roadblock to provider enrollment, the Oregon Health Authority, as the oversight body for the CCOs, responded that CCOs are "given a great deal of latitude in building their provider panels. As long as they are meeting their obligations, they are free to do so." Permitting a financial requirement for enrollment as a provider in a Medicaid network is inappropriate. It is a clear example of insufficient oversight and creates a structural barrier to free choice of providers within that state for Medicaid beneficiaries. This policy has caused the network inadequacy Oregon beneficiaries face when looking for a qualified in-network audiologist or speech language pathologist.

Research done by Georgetown University's Health Policy Institute indicates the incredible variation in standards for network adequacy among all types of health plans.¹⁰ ASHA acknowledges that some federal oversight for Medicaid managed care organization plan networks is required. Unfortunately, due to the Managed care rule promulgated during the previous Presidential Administration, oversight consists of requiring states to choose a

quantitative measure that best suits their needs.¹¹ This often leads to narrower networks and does not promote robust access to care. States cannot rely exclusively on minimum provider to enrollee ratios on a state-wide or sub-region basis, especially when it is not universally enforced across relevant specialties and subspecialties. Enhanced federal oversight is also necessary to ensure that Medicaid managed care organizations and state Medicaid programs maintain provider directories with current information and adequately reflect provider specialties needed to address specific conditions. The inattention provided to network adequacy by the last Administration requires additional effort by CMS to protect and improve beneficiary access.

Time and distance standards for all specialties, but specifically audiology and speech-language pathology, are essential for increasing access to care for Medicaid beneficiaries. Time and distance standards must be employed universally to ensure true access to care, and help beneficiaries avoid long travel times to their provider's office. ASHA recommends that CMS reinstate time and distance standards for all provider types and specialties, especially audiologists and speech language pathologists. In the 2023 Notice of Benefit and Payment Parameters proposed rule, CMS proposed time and distance standards specifically for speech-language pathology services and Medicaid beneficiaries deserve similar protections.¹²

CMS recommends requiring states to adopt a *combination* of standards including time and distance, a minimum percentage of contracted providers willing to accept new patients, maximum wait times for an appointment, and minimum provider to enrollees, among others.

ASHA urges caution regarding telehealth access as a factor in meeting network adequacy requirements. While telehealth is an excellent option for many patients, ASHA stresses that telehealth should supplement, not supplant, adequate in-person network providers. While many audiology and speech-language pathology services may be conducted via telehealth and have seen broad coverage by Medicare, Medicaid, and private health plans; not all services can be rendered remotely. More importantly, some patients and patient circumstances require an in-person evaluation and/or treatment even when the service itself may be appropriate for telehealth with other patients.

ASHA reiterates our request for CMS to provide greater oversight of all aspects of managed care compliance with federal requirements. This includes CMS ensuring provider network information, specifically regarding Medicaid managed care plans, is accurate, timely, and sufficient to meet patient needs. We encourage CMS to implement suggested network adequacy standards in the access to Medicaid services rule planned for October 2022.¹³

- 2. How could CMS monitor states' performance against those minimum standards? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?***

ASHA recommends that CMS consistently require states to report on the combination of network adequacy standards that they have chosen and the ways in which access has improved based on implementing these standards. A report from the Medicaid and CHIP Payment and Access Commission (MACPAC) details that some states do employ multiple components in their network adequacy standards.¹⁴ However, very few states detail publicly the

measures they use to determine access or network adequacy beyond basic information about provider to enrollee ratios. They also do not provide information on how they monitor access and adequacy beyond the statement that the managed care organizations are complying with their contracts.¹⁵ CMS must require managed care companies to make the standards publicly available, along with their compliance reports, and CMS must consistently enforce and consider sanctions when companies do not meet them.

Another area in need of additional oversight is universal enforcement of the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. This statutory requirement (P.L. 90-248) ensures that Medicaid beneficiaries under age 18-21, depending upon the state, receive all medically necessary evaluation and treatment services, such as audiology and speech-language pathology services. ASHA notes the results of the Government Accountability Office's (GAO) report to Congress from 2019 indicated that only half of beneficiaries received recommended EPSDT screenings and services.¹⁶ CMS acknowledged that they do not consistently evaluate state performance against performance measure targets.¹⁷ CMS must monitor all state performance, consistently enforce standards, and provide technical assistance to states that do not meet their obligations under this mandate. EPSDT represents the foundation of comprehensive care to meet the needs of the nation's children and requires aggressive federal oversight to ensure the mandate meets the needs of American children.

The EDPST benefit is mandated, with specific benchmarks for completion and success built in. At a bare minimum, beneficiaries must have access to the mandated care to which they are entitled to. Audiologists and speech-language pathologists provide many EPSDT services to Medicaid beneficiaries under 21, among other services. These beneficiaries face many hurdles to services such as roadblocks by utilization management companies employing prior authorization processes for Medicaid managed care companies and difficulties in network adequacy. EPSDT mandated services cannot be considered optional benefits for states and certain managed care organizations who ignore the federal mandate. Medically necessary developmental services are provided during a critical window for growth and adjustment that can be missed by unlawful delays and denials. **ASHA recommends that CMS clarify that managed care organizations and state Medicaid agencies cannot apply arbitrary visit limitations and onerous prior authorization processes to services required by the EPDST mandate.** All medically necessary services must be provided to Medicaid beneficiaries protected by the EPSDT mandate.

- 3. How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?***

ASHA recommends that CMS require robust coverage of habilitation services and devices for all Medicaid plans. Habilitation services and devices are provided by appropriately credentialed (licensed, accredited, and certified) providers to individuals with many types of developmental, cognitive, physical, and mental conditions that, in the absence of such services, prevent those individuals from acquiring certain skills and functions over the course of their lives. Habilitation

services are closely related to rehabilitation services, although key differences exist between the two.

- **Habilitation** services help a person to attain, maintain, or prevent deterioration of a skill or function they never learned or acquired due to a disabling condition.
- **Rehabilitation** services help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Habilitation services and devices include, but are not limited to, physician services; physical therapy; occupational therapy; speech, language, and hearing therapies for people with brain injuries and other conditions; durable medical equipment (DME), including hearing aids, cochlear implants, augmentative communication devices; and other assistive technology and supplies.

Habilitation services improve long-term function and health status and improve the likelihood of independent living and quality of life. These services and devices may also halt or slow the progression of primary disabilities by maintaining function and preventing further deterioration of function to help enable persons with developmental, intellectual, physical, or cognitive impairments to improve cognition and functioning.

Habilitation services and devices are an important element of whole person care but are not universally covered in Medicaid plans. For example, Arizona's Medicaid program does not cover outpatient speech-language pathology services *at all* for individuals aged 21 or over.¹⁸ In 2018, only a little over half of states provided Medicaid coverage for hearing aids for individuals aged 21 and over.¹⁹ The need for speech, language, swallowing, and hearing services do not end on one's 21st birthday, especially for individuals with disabilities and chronic conditions. ASHA notes that CCIO's work to enforce the essential health benefits under the ACA might be instructive to CMS's efforts to ensure comprehensive coverage for Medicaid beneficiaries and we urge CMS to partner with stakeholders, such as ASHA, to educate state Medicaid agencies on the value of comprehensive coverage for adults in need of habilitative and rehabilitative services.

4. *In addition to existing legal obligations, how should CMS address cultural competency and language preferences in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?*

Linguistic diversity in the United States continues to impact the way in which audiologists and speech-language pathologists conduct business. According to a 2016 American Community Survey on language use in the United States, more than 65 million people use a language other than English and more than 1,000 different languages are spoken.²⁰ The number of languages used and the number of individuals who require services in a language other than spoken English far exceed the capacity of bilingual service providers to accommodate them. Therefore, it may be necessary for the clinician to collaborate with an interpreter, transliterator, or translator to ensure clinically appropriate services. Furthermore, legal and ethical standards require that services to individuals who use a language other than spoken English must be delivered in the language most appropriate to that student, client, patient, or family.²¹

ASHA recommends for CMS to require states to offer materials in as many languages as are served in that region, or as many languages as possible because of the need to offer clinically appropriate services. For example, California's Medi-Cal program offers materials in 17 languages.²² Recognizing the unique challenges in each state Medicaid program, CMS may partner with stakeholders, including consumer and provider advocacy organizations, to determine when more diverse resources are needed. Once this information is known, CMS could generate common resources and standards, where possible, to support a variety of state Medicaid budgets.

5. What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

ASHA suggests that CMS recommend a universal adoption of telehealth coverage across professions included in state Medicaid programs, especially for audiologists and speech language pathologists. ASHA strongly supports the use of telehealth. Research demonstrates the equivalence of telehealth to in-person service delivery for a wide range of diagnostic and treatment procedures for adults and children.²³ Studies have shown high levels of patient, clinician, and parent satisfaction supporting telehealth as an effective alternative to the in-person model for delivery of care.²⁴ Telehealth expands practitioners' availability to those in need—regardless of geographic location—saving time and resources for both the provider and the patient. Despite proven benefits, telehealth remains underutilized within audiology and speech-language pathology due to inconsistent adoption by state Medicaid programs. To help provide a foundation for coverage across disciplines, CMS could share with states the list of codes currently covered by Medicare.

ASHA acknowledges that CMS must also work to address telehealth payment considerations and support telehealth coverage at parity with in-person services to encourage robust telehealth offerings in Medicaid programs. Twenty-nine states and Washington, DC, have passed telehealth parity laws; however, the remaining states' insurers are beginning to reduce reimbursement rates to providers who are offering telehealth services. Providers have many fixed costs regardless of the manner of services delivery, which may include labor, HIPAA compliant software, and hardware needed for telehealth delivery. In addition, the costs of overhead are not significantly reduced when health care practitioners provide a small subset of their overall services via telehealth. A journal article by Snoswell, Taylor, Comans, Smith, Gray, & Caffery (2020) concludes, "Health services considering implementing telehealth should be motivated by benefits other than cost reduction. The available evidence has indicated that although telehealth provides overwhelmingly positive patient benefits and increases productivity for many services, current evidence suggests that it does not routinely reduce the cost of care delivery for the health system."²⁵ There are many benefits to telehealth for insurers and beneficiaries alike but reducing payment to telehealth providers undercuts those benefits and risks ongoing access.

ASHA recommends that CMS help educate state Medicaid programs about the value of interstate practice compacts and how provider licensing functions under them. ASHA-certified audiologists and speech language pathologists often have difficulty obtaining multiple state licenses to practice across state lines due to administrative burdens. These burdens hinder their

ability to provide quality services and restrict consumer access in underserved and rural communities. Education about the Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC) at the state Medicaid agency level will help agencies learn best practices for implementation and provider licensing questions that may arise.²⁶

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community-based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

4. How should CMS consider requiring states to report standardized data on Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes that address enrollment in coverage and access to services? How could these data be used to meaningfully monitor access?

ASHA recommends that CMS rigorously monitor and require states to document data on Medicaid fair hearings, CHIP reviews, and managed care appeals and grievances. Firm deadlines should also be set for responses from plans to beneficiaries and providers once the notice of appeal is provided. In addition, reasonable standards should be set for turnaround times. ASHA members experience frustration with managed care appeal processes that often span for months at a time.

For example, a common method of provider and patient appeal, the peer-to-peer review, is functionally absent from the appeals process for Colorado Medicaid's utilization management program. While the peer-to-peer review concept is listed as an option in the plan, the utilization management company used by Colorado's Medicaid program, Kepro, requires three different days of availability, at any time on those days, from any physician referral source. It is virtually impossible for a primary care provider (physician) to provide this availability for what is primarily a speech-language pathology appeal. This requirement for all providers eliminates peer-to-peer review for any beneficiary seeking an appeal. Beneficiaries must escalate their review to the Fair Hearing level, which could take months (over 100 calendar days in some cases). Kepro in Colorado, like many utilization management companies, also forbids the rendering therapist from participating in the peer-to-peer appeal review; thereby, eliminating the referring provider who prescribed the services of the therapist for their specialty knowledge and expertise in this area. These are just a few examples of the roadblocks that beneficiaries and providers face as part of an intentionally difficult and biased appeal process.

ASHA recommends that CMS track how many Medicaid beneficiaries' denials are appealed, are escalated to the Fair Hearing stage, the increase/decrease in denials over a period of time, and comparing those changes between similarly situated states. Once CMS gathers that data, CMS should intervene with oversight, education, and enforcement when state programs struggle to meet reasonable expectations and benchmarks. CMS should also sample appeal cases to learn more about patterns that may arise. This close oversight would greatly benefit Medicaid beneficiaries and enrolled providers.

In addition, ASHA recommends that CMS develop mechanisms to receive feedback from stakeholders, including beneficiaries, providers, and family caregivers, when managed care entities engage in inappropriate restrictions of coverage or denial for individual claims, and when they face onerous appeals requirements.

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. Section 1902(a)(30)(A) of the Social Security Act (the “Act”) requires that Medicaid state plans “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States “in an effective and efficient manner....” CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.

- 1. What are the opportunities for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?***

ASHA suggests that CMS, at a minimum, implement a mandate for managed care companies to not offer reimbursement rates lower than what is included on the state’s fee-for-service fee schedule. The proliferation of state Medicaid programs has come at a cost to providers in many ways. Many managed care organizations reimburse providers at rates lower than traditional fee-for-service programs, which are often prohibitively low for many providers already. Low reimbursement rates discourage provider participation; thus, creating narrower provider networks for beneficiaries.

Another version of low provider reimbursement rates that negatively impacts patient care is seen in Florida’s Medicaid program, where providers are offered extremely low capitated payments for each beneficiary. Their current program places the obligations to provide all medically necessary services on the provider without an effort to ensure reimbursement aligns with beneficiary need. ASHA strongly recommends that CMS provide greater oversight to such proposals and ensure that reimbursement meets the expected needs of beneficiaries based on their individual condition and the utilization levels of similarly situated individuals.

ASHA urges CMS to recommend state Medicaid programs to set their fee schedules to no less than those afforded by Medicare. While Medicare rates still do not adequately account for all costs and services provided by audiologists and speech-language pathologists, some state Medicaid programs reimburse at a fraction of the Medicare rate. Reimbursement rates undoubtedly affect provider participation. Higher provider payment rates are associated with

higher rates of accepting new Medicaid patients.²⁷ While ASHA understands that states have much flexibility in determining their rates for providers, following Medicare's fee schedule, *at a minimum*, should be a recommended best practice.

Sharing the Medicare fee schedule rates with state Medicaid agencies, with a recommendation of review and adoption as a foundation for payment, would also help ensure that states reflect the concept of relative value in their individual fee schedules. CPT codes are developed according to an extensive process of peer review conducted by the American Medical Association's Relative Value Scale Update Committee (RUC). This process allows the RUC to ensure that payment for various services accurately reflects the work, risk, skill, and time of procedures in relation to other codes. ASHA notes that many states arbitrarily pay for certain services with no connection to the relative value of those services. Such variations undermine access to care because inadequate reimbursement makes service delivery impossible.

- 3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?***

As mentioned in question 1, current Medicaid rates do not comprehensively capture the many costs audiologists and speech language pathologists incur when offering services to beneficiaries. Medicaid's rates fail to reimburse the labor and many overhead costs that ASHA members incur while running a practice. ASHA suggests that CMS engage with provider groups, including ASHA, to best develop the fair market value of services provided by audiologists and speech language pathologists

For example, one of the ways audiologists identify hearing loss is through use of an auditory brainstem response (ABR) test.²⁸ The Vivosonic branded machine that is often used in this test costs \$23,000. The Pennsylvania Medicaid fee schedule reimburses \$70.30 for the relevant CPT© code used to bill these services. The machine mentioned is just one of many that audiologists must use in daily practice, and those machines all have considerable price tags. Providers are expected to outfit their practices with the necessary machinery and skill without receiving reimbursement reflective of their investment.

Furthermore, CMS may engage with provider groups who can identify states with policies that better reflect the costs of services. For example, Mississippi Medicaid previously reimbursed hearing aid suppliers at \$256 per hearing aid, a tiny fraction of the cost of this item. After a robust education campaign with many stakeholders, Mississippi Medicaid raised their reimbursement rate to \$1,600 per hearing aid. This example shows both the power of stakeholder engagement and the stark difference in reimbursement rates versus the cost of services and supplies.

ASHA recommends that CMS engage with organizations, including ASHA, to develop resources and guidance based on fair market value for services for state Medicaid programs to look to when developing reimbursement rates for their states.

ASHA contracts with data collection and actuarial agencies to determine the typical reimbursement rates for audiology and speech-language pathology services across various payers including Medicare, private health plans, exchange plans, Medicaid, and Medicaid Managed Care. While this data does not address the appropriateness of payment, they do provide a snapshot of the reimbursement landscape associated with the services ASHA members provide. ASHA would welcome the opportunity to share this data with CMS and discuss appropriate levels of reimbursement as demonstrated by the report and related beneficiary access and coverage issues across various states.

- 4. Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries. What actions could CMS take to encourage states to reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?***

Prior Authorization Processes

According to the Kaiser Family Foundation, more than two-thirds of all Medicaid beneficiaries receive most or all their Medicaid benefits through managed care companies.²⁹ Most managed care companies employ prior authorization before beneficiaries may receive services. ASHA recognizes the importance of program integrity and understands the ultimate goals of prior authorization; however, in some circumstances, prior authorizations have been used to limit access to care for medically necessary services to increase corporate profits. States have an obligation to ensure that beneficiaries receive the care they are entitled to, and CMS must ensure that states fulfill that obligation.

Under Medicaid managed care, utilization management companies often establish arbitrary limitations on the frequency, duration, and intensity of audiology and speech-language pathology services without consideration of the individual needs of the patient. Such limitations are problematic for all beneficiaries but represent a violation of the EPSDT mandate when applied to children.

Arbitrary limitations, paired with the frequent need to reauthorize treatment, negatively impact continuity of care and related patient outcomes. For example, for children whose Medicaid benefits are covered based on the EPSDT benefit where utilization management companies have established limitations and restrictions. This prevents children from accessing these benefits because there is not a transparent pathway to ensure access to medically necessary, federally mandated care and there is little oversight to ensure the entitled care is authorized and delivered.

Delayed turnaround times on prior authorization remains problematic to CMS and state Medicaid agency monitoring efforts. Turnaround times, or the time from submission of the prior authorization request (PAR) to the time it is approved or denied, need to remain low to ensure providers can see patients as soon as possible to begin treatment. Many Medicaid managed care companies have reported low turnaround times on PARs. This falsified reporting is supported by changing the actual date of submission of the PAR to the date of when the utilization management company received everything necessary to make a determination on a claim. This is incredibly problematic for providers who often find inconsistent or changing

guidance on PAR submission or are constantly asked for more information and documentation that is not initially requested upon submission or even available in the policy governing PARs.

While some managed care utilization management companies have established efficient and timely prior authorization processes, it is not uncommon for PARs to take weeks or even months to complete. This process results in utilizing staff hours and provider time to navigate the processes and leaves patients without care.

Prior authorizations and associated delays have real implications for patient safety and for broader costs to state Medicaid programs. For example, patients discharged from the hospital or rehabilitation facility after a stroke often need swallowing therapy from a qualified speech-language pathologist. In many states, outpatient speech-language pathology services require prior authorization. ASHA members report that patients, while waiting for authorizations, are frequently readmitted to the hospital because they are unable to swallow, experience choking episodes, and/or develop pneumonia from the associated difficulties in swallowing. Utilization management companies cite the availability of emergency prior authorization processes with faster review decisions. Unfortunately, for individuals in need of immediate services for daily living activities, *any* delay can lead to serious adverse events.

ASHA suggests that CMS increase oversight for the use of prior authorization plans. For example, implementing stronger directives to state Medicaid agencies, managed care companies, and their utilization management companies may better identify situations where fraud and abuse has been shown or where large and unusual spikes in claims have occurred with no explanation. ASHA also urges CMS to review the list of services that each plan subjects to prior authorization and ensure that Medicaid beneficiaries receive information from their plans about the use of prior authorization and how they may appeal any subsequent denials of their care in a timely fashion.

Paperwork Burden

CMS has noted the “school setting provides a unique opportunity to enroll eligible children in the Medicaid program, and to assist children who are already enrolled in Medicaid to access the benefits available to them.”³⁰ Federal law allows local school districts to receive reimbursement for medically necessary services provided to Medicaid eligible children in schools and for performing various administrative activities such as Child Find activities.³¹ However, CMS requires schools to comply with similar processes, documentation, and claiming requirements applicable to other health care providers, which can be burdensome for smaller school districts. In December 2018, AASA, the School Superintendents Association, surveyed over 750 school leaders in 41 states about their participation in the school-based Medicaid program and found the complex administrative and paperwork requirements necessary to obtain Medicaid reimbursement significantly hindered the school district’s participation in the program.³² Therefore, ASHA encourages CMS to review and replace existing guidance, such as the 2003 Medicaid School-Based Administrative Claiming Guide, or propose further guidance to reduce administrative barriers to providing and obtaining reimbursement under Medicaid for health care services provided in school settings.

Medicaid and the Individuals with Disabilities Education Act

Audiologists and speech-language pathologists who work in schools face a tremendous paperwork burden. A 2016 Government Accountability Office (GAO) report noted that providers who serve students under the Individuals with Disabilities Education Act (IDEA) spend 2 to 3 hours per day on administrative tasks, or roughly 20%-35% of their time.³³ However, an earlier

GAO report found that “Medicaid documentation requirements are more burdensome than those of IDEA.”

ASHA recommends that CMS collaborate with the Department of Education to provide guidance, training, technical assistance, and state capacity building to support the interoperability and streamlining of IDEA and Medicaid reporting systems. It is critical to reduce the paperwork burden faced by audiologists and speech language pathologists working in schools and serving student services through IDEA and reimbursed by Medicaid. A streamlined reporting system would help ensure that information and data, including demographics, may be input once, and replicated automatically as needed.

ASHA recommends that CMS and the Department of Education collaborate on issuing provider guidance so that the inclusion of a diagnosis in an Individualized Education Plan (IEP) also meets the standard of a physician order for state Medicaid programs. An existing barrier to accessing Medicaid reimbursement is that the inclusion of a medical diagnosis on an IEP does not always qualify, or meet the standard, of a physician order for some state Medicaid programs. Seeking a physician order for these services is an unnecessary step for providers when a medical diagnosis is already present on the IEP. This guidance could clarify that services included in an IEP related to a medical condition are allowable and recommended as qualified Medicaid services. Some states do not take advantage of this flexibility and it could lead to greater access to services.

Provider Credentialing

While ASHA understands that the pandemic has caused uniform delays throughout the health care system, providers continue to face extensive delays in credentialing through Medicaid managed care plans. ASHA members have reported waiting as long as six to nine months to become credentialed with a plan. ASHA recommends CMS set limits on wait times for credentialing of eligible providers in plans. This would require managed care companies to appropriately address provider enrollment and credentialing processes.

ASHA suggests that CMS direct state Medicaid programs to provide guidance on baseline credentialing requirements so that providers may apply to multiple available plans. Provider enrollment is variability in the credentialing processes is another barrier for providers. Variability in requirements and processing times lead to delays in enrollment and subsequent delays in patient care.

Greater Transparency

ASHA recommends that CMS direct all state Medicaid programs to issue state-specific, clear, and appropriate guidance explaining how individuals, families, schools, and school districts can best access, bill, and provide Medicaid related services. Many school districts have trouble accessing school-based Medicaid due to a lack of clear state-level guidance and process transparency. While some states issue guidance that clearly articulates the process for school districts to access, bill, and provide Medicaid related services, many do not. This would help mitigate this transparency gap and facilitate greater access to services for children who already qualify.

Using Health Insurance Portability and Accountability Act (HIPAA) to Ensure Consistent and Efficient Coding Across Payers

HIPAA established administrative simplification (AS) provisions to ensure uniform communications across the health care sector through mandatory use of standard code sets that describe diagnoses (International Classification of Diseases or ICD), procedures (Current


Procedural Terminology or CPT), and medical supplies and equipment (Healthcare Common Procedure Coding System or HCPCS).³⁴ However, some private payers and state Medicaid agencies significantly modify these code sets for their own purposes. These modifications change the original intent of the code(s) and, by doing so, cause confusion and place a significant administrative burden on providers who must track the variable use of established codes by different payers.

For example, some state Medicaid agencies, such as Idaho Medicaid, require providers to bill CPT code 92507 (treatment of speech, language, voice, communication, and/or auditory processing disorder) in 15-minute units.³⁵ However, the American Medical Association's (AMA) CPT Editorial Panel published 92507 as an untimed code that may only be billed once per-day, regardless of the length of the treatment session. Florida Medicaid also recognizes CPT code 92507 as timed and requires providers to bill *many* speech-language pathology related therapies under this single code, even though there may be CPT codes that better describe the specific speech-language pathology services provided.³⁶ Such variances in code use among payers diminish the impact of HIPAA's AS provisions and have significant implications for utilization, claims data analysis, and accurately using established codes.

To resolve this problem, **ASHA urges CMS to use its authority to direct Medicaid agencies to comply with the standard guidelines for each code set, as established by each responsible entity** (e.g., the AMA for the CPT code set). ASHA also urges CMS to explore options for enforcing correct coding procedures across all payers, in accordance with HIPAA AS requirements.

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,



Judy Rich, EdD, CCC-SLP, BCS-CL
2022 ASHA President

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