ASHA
American
Speech-Language-Hearing
Association

August 7, 2019

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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; Reducing Administrative Burden to put Patients over Paperwork

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Request for Information; Reducing Administrative Burden to put Patients over Paperwork that was published in the *Federal Register* on June 11, 2019.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 204,000 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 topics discussed in the request for information (RFI):

- Modification or streamlining of reporting requirements, documentation requirements, or processes to monitor compliance to Center for Medicare & Medicaid Services (CMS) rules and regulations;
- Aligning of Medicare, Medicaid and other payer coding, payment and documentation requirements, and processes;
- Enabling of operational flexibility, feedback mechanisms, and data sharing that would enhance patient care, support the clinician-patient relationship, and facilitate individual preferences;
- New recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, and providers; and
- Address specific policies or requirements that are overly burdensome, not achievable, or cause unintended consequences in a rural setting.

Modification or streamlining of reporting requirements, documentation requirements, or processes to monitor compliance to CMS rules and regulations

Certification and Recertification of the Therapy Plan of Care (Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3)

Currently, Medicare requires a physician involved in the patient's care to certify the speech-language pathologist (SLP) developed plan of care within 30 days of its development and recertify the plan periodically as necessary. The same certification and recertification

requirements apply to physical therapists and occupational therapists. While a plan of care is important for the purposes of care planning and documentation, certification is unnecessary. ASHA strongly encourages CMS to eliminate this burdensome requirement.

The certification/recertification requirement does not add value or improve the quality of care for Medicare beneficiaries. Rather, it is a "check the box" requirement that adds an administrative burden on SLPs and physicians. If SLPs cannot get the plan of care signed, the payment consequence is applied to them instead of the physicians who must often be reminded to provide certification. The certification requirement also fails to recognize the clinical graduate education and expertise of the SLP. In practice, the SLP develops the plan of care independently and the physician rarely modifies or even thoroughly reviews the plan. CMS does not require a physician order and no state licensure laws specifically require a physician order for speech-language pathology services. Further, SLPs complete an accredited master's program and are licensed in every state. Finally, ASHA's Certificate of Clinical Competence (CCC) demonstrates the SLP has voluntarily met rigorous academic and professional standards that often go beyond the minimum requirements for state licensure.

For these reasons, ASHA requests the elimination of the certification requirement for therapy plans of care and instead recommends CMS replace certification with a requirement that the treating physician receive a copy of the plan of care to enhance effective interdisciplinary practice and care coordination.

Consolidated Billing for Home Health Services

ASHA recognizes that the law requires consolidated billing for home health services to help ensure program integrity.[1] However, implementation of this policy is flawed and has a negative impact on SLPs in private practice. There are inadequate requirements and accountability for home health agencies to "claim" a patient in a timely fashion and provide the full constellation of medically necessary services that the beneficiary requires. Therefore, CMS should require a Notice of Admission (NOA) of home health benefits be filed by the home health agency within five days of admission of the patient, similar to the NOA required under the hospice benefit. The current enforcement mechanism used by CMS to address delays in "claiming" patients—the request for anticipated payment (RAP)—has proven ineffective and is being eliminated as a result. CMS must replace the RAP with a more effective mechanism to ensure that beneficiaries receiving home health care are clearly identified and receive all medically necessary services from their home health agency. ASHA appreciates and supports the proposal in the calendar year 2020 home health agency prospective payment system proposed rule.

If a patient is under a Part A home health plan of care and an SLP in private practice also sees this patient at the beneficiary's request because they have an unmet need, then the SLP will be denied reimbursement despite the good faith efforts of the SLP to determine if home health consolidated billing applies by asking patients if they receive services in their homes and checking the common working file (CWF) administered by CMS. Because home health agencies fail to submit the RAP or a claim that would indicate a home health episode has been initiated in the CWF, an SLP might provide medically necessary services for a patient and be denied reimbursement for these services. By implementing an NOA that would preclude payment for each day that the NOA was not filed, the appropriate financial

incentives would drive timely notice and claim submission to ensure that the CWF was as updated as possible.

Medicare Quality Reporting Requirements

Streamlining and aligning the various reporting requirements related to quality and service provision are essential because disparate programs with varying measures, requirements, and goals do not drive practice toward efficiency and quality. An example of an attempt to unify data collection and measures across the various post-acute settings is the Improving Medicare Post-Acute Transformation (IMPACT) Act. The disconnect between the IMPACT Act and the Merit-Based Incentive Payment System (MIPS) are examples where additional alignment and streamlining are necessary.

ASHA supports and understands the importance of ongoing quality reporting at both the facility and individual clinician levels. However, disparate reporting requirements, measures, and mechanisms are burdensome and potentially counter-productive. CMS should make every effort to align and harmonize reporting under the IMPACT Act and MIPS. Facility-based clinicians who provide Part B services must also be allowed a meaningful yet unobtrusive way of participating in the MIPS program. ASHA encourages CMS to consider how facility-based clinicians can participate in MIPS.

Qualified Clinical Data Registries (QCDRs) are increasingly important in collecting, aggregating, and analyzing the growing amount of data being reported on health care services under Medicare and across all payers. For the past 15 years, ASHA has operated an outcomes measurement system that was recognized for functional limitation reporting and is currently making the necessary modifications to meet the requirements of a QCDR. ASHA is committed to helping our members successfully report MIPS data, but more importantly, to collect quality and outcomes data to help drive best practices and demonstrate the value of ASHA member services to consumers.

In order to facilitate the development of QCDRs and specialty-based measures that meaningfully demonstrate quality, outcomes, and drive best-practices, ASHA urges CMS to provide greater transparency on the requirements and the review process for measure approval and registry recognition. As CMS knows, measure and registry development are complex and costly undertakings. Clear guidance and consistency from CMS in the standards for development, approval, and maintenance are critical. ASHA is committed to collecting and using data to inform best practices for audiologists and SLPs and to deliver improved outcomes for beneficiaries. These suggestions will help ASHA and other societies accomplish these goals more effectively and efficiently.

Part B Student Supervision Requirements (Medicare Benefit Policy Manual, Chapter 15, Section 230.B1)

Medicare requirements for the supervision of students providing services to Medicare beneficiaries are restrictive and burdensome. CMS requires 100% personal supervision of students who provide outpatient services to Medicare beneficiaries. This requirement is antiquated because it does not consider the supervision options available and creates a clinical training bottleneck for new practitioners. ASHA urges CMS to require direct supervision for students rather than the current standard of 100% personal supervision.

Direct supervision would continue to provide needed oversight and patient protections by requiring the supervisor to be onsite, immediately available to respond as needed, and ultimately responsible for the delivery of patient care. The Bureau of Labor Statistics notes that speech-language pathology is a profession expected to grow much faster than average to meet the growing demands created by changing demographics.[2] Providing more flexible supervision options for universities would allow them to train more students and help address the growing need for additional SLPs.

ASHA encourages CMS to amend the definition of direct and personal supervision to recognize onsite tele/video-supervision as additional solutions to reducing the burden of important, but restrictive, supervision requirements.

Reduce Paperwork Burden on School-Based Audiologists and SLPs

Medicaid school-based administrative claiming

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."[3] Federal law allows local school districts to receive reimbursement for medically necessary services provided to Medicaid eligible children in their schools and for performing various administrative activities such as outreach to identify eligible children and enrolling children in the Medicaid program.[4] However, CMS requires schools to comply with similar processes, documentation, and claiming requirements that are applicable to the treatment practices of other health care providers, which is especially 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 school district participation in the program.[5] Therefore, ASHA encourages CMS to review 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 SLPs 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 2-3 hours per day on administrative tasks, or roughly 20%-35% of their time.[6] And yet, the same report noted an earlier GAO report found that "Medicaid documentation requirements are more burdensome than those of IDEA." To reduce the paperwork burden faced by audiologists and SLPs who work in schools and serve students accessing services through IDEA and who are billing Medicaid, ASHA recommends that Center for Medicaid and (Children's Health Insurance Plan (CHIP) Services (CMCS) coordinate with the Office of Special Education and Rehabilitative Services within the Department of Education to develop trainings and provide technical assistance with billing and payment administration for Medicaid services in schools and reduce the total paperwork burden for school-based clinicians who utilize IDEA funds and bill Medicaid.

Develop Transparent Requirements for Managed Care Companies Offering Medicare and Medicaid Benefits

According to the Kaiser Family Foundation, more than half of all Medicaid beneficiaries receive most or all of their Medicaid benefits through managed care companies and roughly 30% of Medicare beneficiaries are enrolled in Medicare Advantage.[7,8] While these plans are required to provide the benefits covered under the traditional programs, they are given tremendous latitude and little oversight. For example, a GAO report found that CMS reviewed less than 1% of Medicare Advantage plan provider networks to check for adequacy and accuracy.[9] Given the increasing number of patients receiving service through managed care, CMS should take immediate steps to ensure appropriate oversight of Medicaid managed care and Medicare Advantage plans. Additionally, CMS should develop mechanisms to receive feedback from stakeholders, including beneficiaries, providers, and family caregivers, when managed care entities engage in inappropriate restrictions of coverage or denials of individual claims.

Managed care companies are engaging utilization management entities and techniques to make benefit determinations, which often restrict benefits otherwise covered by traditional Medicare and Medicaid. For example, while no Medicare Advantage plan has published that it does not cover services in inpatient rehabilitation facilities, utilization management techniques are used to steer nearly all patients, regardless of need, to lower cost skilled nursing facilities. Under Medicaid managed care, utilization management companies inappropriately establish limitations on the frequency, duration, and intensity of therapy services without consideration of the individual needs of the patient. These 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 federally-mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, utilization management companies have established limitations and restrictions, which prevent children from accessing these benefits with no transparent pathway to ensure access to medically necessary care and no oversight mechanism to ensure the entitled care is delivered.

The challenges created by having disparate requirements between Medicare, Medicaid, and different managed care entities represent enormous administrative burdens for health care providers. Streamlining these requirements across payers and/or establishing some standardized timelines and parameters for utilization management decisions would greatly reduce this provider burden and improve access to medically necessary care for patients.

Medicaid Work Requirements

Many states have implemented work requirements as a condition for enrolling in Medicaid. States often reference their leniency in what is considered meeting the work criteria (e.g., serving as caregivers, volunteers) but inappropriate application of these administrative requirements can result in inappropriate termination from the program forcing re-application and avoidable gaps in coverage and medically necessary treatment.

As noted by the Center for Budget and Policy Priorities, the imposition of work requirements can significantly harm children, elderly, and individuals with disabilities; particularly burdensome work requirements that such vulnerable populations cannot meet due to underlying health conditions, disabilities, or other functional impairments.[10] The administrative costs of monitoring and enforcing work requirements undermine the financial

savings theoretically obtained by reducing enrollment and restricting access to health care coverage for citizens who have medically necessary needs. ASHA recommends that CMS re-evaluate how work requirements for Medicaid eligibility impact access to medically necessary care for low-income American citizens in need of health care coverage. If these requirements remain in place, CMS should establish standards that avoid dis-enrollment of individuals without access to other health insurance coverage and ensure that the burden imposed on Medicaid beneficiaries and state Medicaid agencies for monitoring and enforcing work requirements do not ultimately reduce the availability of federal and state funds for providing medically necessary care to enrolled Medicaid beneficiaries.

Aligning of Medicare, Medicaid and other payer coding, payment and documentation requirements, and processes

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).[11] However, there are private payers and state Medicaid agencies that significantly modify these code sets for their specific 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 how code sets are applied by different payers. For example, ASHA is aware of state Medicaid agencies, such as Idaho Medicaid, that require CPT code 92507 (treatment of speech, language, voice, communication, and/or auditory processing disorder) to be billed in 15-minute units. However, 92507 was published by the American Medical Association's (AMA) CPT Editorial Panel as an untimed code that is only meant to 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 *all* speech-language pathology related therapy under this single code, even though there are others within the code set that better describe the constellation of speech-language pathology services, such as swallowing treatment (92526). Such variances in code use among payers diminish the impact of HIPAA's AS provisions and have significant implications for utilization and claims data analysis.

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.

CMS Publication of Relative Value Units (RVUs) for Use by All Payers

Currently, CMS does not consistently publish RVUs for certain CPT codes that do not meet the programmatic needs of Medicare or that represent services that are not covered under the Medicare benefit. For example, CMS determined that it would not accept CPT 97127 (cognitive function intervention) as a valid code and replaced it with its own Medicare G-code. As a result, CMS did not publish the RVUs for 97127 that were recommended by the

AMA Relative Value Update Committee (RUC). However, other payers, including state Medicaid agencies, opted to use 97127 as published in the CPT codebook. Providers have since reported that reimbursement is inconsistent with the AMA's recommended relative values for 97127. Therefore, ASHA requests CMS publish RVUs for all CPT codes that are valued through the RUC process to ensure transparency, uniformity, and appropriate coverage by Medicaid and other non-Medicare payers.

Convene a Stakeholder Group to Align Quality Reporting Requirements Across all Payers

The type, amount, and use of quality data varies across the health care sector. Private insurers have developed a wide array of quality measures and programs. Medicare has quality reporting programs in the four post-acute care settings as well as MIPS for outpatient services. Some quality reporting programs apply penalties for failure to meet targets, while others penalize participants for failing to report the data. Still other programs reward clinicians and facilities for meeting certain quality objectives or benchmarks. As a result, clinicians and facilities struggle with disparate, uncoordinated, and, in some cases, contradictory quality reporting requirements. CMS should consider its role as a convener of stakeholders to identify a coordinated plan for advancing the quality and value agenda for patients. CMS should use its authority and leadership platform to establish some uniform principles, if not a unified approach, to quality reporting across payers that would greatly reduce provider burden in the critical area of quality reporting and continuous performance improvement. ASHA recognizes some work is underway in this area and encourages CMS to continue to focus on using its influence to improve the alignment of quality reporting across payers.

Enabling of operational flexibility, feedback mechanisms, and data sharing that would enhance patient care, support the clinician-patient relationship, and facilitate individual preferences

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Recognition of Nonphysician Providers for Technology-Based Communication Services

ASHA supports CMS's efforts to modernize Medicare payment for technology-based communication services and initiatives to improve patient access to all members of the health care team. Technology-based services can be leveraged to improve timely access to care and avoid overutilization and preventable adverse events.

Nonphysicians regularly use technology-based services in a variety of ways, including to:

- support a sustainable transition from active therapy to self-management by monitoring a patient's performance of a home program using communication technology; and
- monitor meaningful data related to functional benchmarks to determine appropriate tasks for patients with, or at risk for, functional decline.

Examples of technology-based communication services include:

- Virtual check-in (G2012)
- Interprofessional internet consultation (99446-99449 and 99451-99452)
- Telephone and online assessment and management services (98966-98969)

Most nonphysician qualified health care professionals, including audiologists and SLPs, are not compensated by Medicare for using communication technology to assess and determine whether additional services are indicated.[12] This significantly limits patient access to these necessary services and the ability of nonphysicians to effectively manage health care costs and ensure optimal patient outcomes.

However, ASHA is pleased to see the recent proposal by CMS to allow payment for online digital assessments provided by qualified nonphysician health care professionals (HCPCS codes GNPP1-GNPP3).[13] We encourage CMS to continue its efforts to appropriately reimburse all members of the health care team for using other technology-based services (e.g., G2012 for virtual check-in) to ensure timely access to care and to determine if other health care services are necessary.

Direct Access to Audiology Services

ASHA has worked with other audiology stakeholders to successfully introduce legislation that would put the needs of patients over unnecessary paperwork by allowing audiologists to treat patients without a physician order. We know that individuals with mild hearing loss are three times more likely to experience a fall, and falls are the leading cause of fatal injury for Americans over 65.[14,15] In addition, seniors with hearing loss are more likely to develop cognitive problems and experience cognitive decline up to 40% faster than those with normal hearing.[16] For all individuals, untreated hearing loss can lead to depression, anxiety, and social isolation.[17] Finally, timely access to diagnosis and treatment for hearing and vestibular conditions can improve outcomes for beneficiaries and reduce overall cost of care.[18] While audiologists are health care professionals licensed in all 50 states and the District of Columbia who are trained in the diagnosis, treatment, and rehabilitation of individuals with hearing, balance, and related disorders, unnecessary paperwork is being undertaken and patients are facing a delay in care due to the requirement for a physician's order before an audiologist may provide diagnostic services under Medicare.[19, 20]

ASHA's legislation would remove the physician order requirement for patients seeking care from audiologists to better align with the Department of Defense Medical Health System, the Veterans Health Administration (VHA), the Office of Personnel Management (through many of its Federal Employees Benefit plans), as well as many Medicaid and private health plans, which provide patients "direct access" to audiologists and do not require patients to receive physician orders.[21, 22, 23, 24] In fact, the VHA has noted that administrative requirements for referral, plan of care, consultation with the attending physician or other health care practitioner, and oversight delay care and may increase costs.[25] While ASHA recognizes that such a change requires Congressional action, we welcome the opportunity to discuss this legislative proposal and request your support for the legislation in the interest of reducing unnecessary administrative burdens that hinder access to care for Medicare beneficiaries.

New recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, and providers

Development of Explicit Guidance Regarding Beneficiary Liability

Medicare clinicians are subject to a variety of statutory, regulatory, and sub-regulatory guidelines related to coverage of their services. However, Medicare clinicians are lacking explicit guidance regarding beneficiary liability when these coverage requirements are not met and when to use the advanced beneficiary notice (ABN). In the absence of such guidance, many clinicians refrain from providing services in such a manner because of the general understanding that, if a service is covered, it should always be provided in a manner that complies with all forms of coverage guidance and there is no beneficiary liability. However, recent anecdotal evidence of sub-regulatory guidance from CMS suggests additional clarification is needed. ASHA specifically requests clarification regarding the beneficiary liability associated with the following scenarios.*

Telehealth

At this time the categories of clinicians authorized under federal law to provide services via telehealth are restricted to select clinical disciplines and do not include audiologists and SLPs. Further, federal law restricts the provision of telehealth services to rural areas. Additionally, through a regulatory process, CMS has established that only select services, excluding audiology and speech-language pathology, are eligible telehealth services. Therefore, would it be appropriate for an audiologist or SLP, particularly in an urban area, to charge a patient directly for those services because they do not meet any of the statutory or regulatory requirements for Medicare telehealth coverage? This presumes that the audiologist or SLP is authorized under state law to provide services via telehealth and that the patient is an appropriate candidate for telehealth.

Part B Therapy Student Supervision Requirements

As noted above, Medicare regulatory policy requires that therapy students receive 100% personal supervision by a licensed therapist to meet program requirements. Additionally, the Social Security Act defines a qualified SLP as an individual who is licensed in their state. Currently, no state licenses speech-language pathology students. Given the statutory and regulatory prohibitions on billing for student services, if the level of student supervision is less than 100% personal supervision, would the beneficiary be liable for services provided by a student?

Compliance with Local Coverage Determinations

On occasion, local coverage determinations place coverage restrictions on speech-language pathology services. For example, they might not cover services associated with specific CPT or ICD codes. Additionally, there is no federal guidance in outpatient settings regarding the use of group therapy but some local coverage determinations place restrictions on group size such as limiting the group to four patients. If an SLP is providing medically necessary services within their scope of practice to a group of six patients, which

* Each of the listed scenarios presume that the provider is practicing within their state established scope of practice and has obtained informed consent from their patient.

does not comply with the requirements of an applicable LCD, is the beneficiary financially liable?

In each scenario, ASHA requests comment regarding the beneficiary's liability as well as whether there is an obligation for the treating provider to furnish the patient with a mandatory ABN.

Development of Regulations and Policies That Go Beyond Utilization Data
Concerns about increased utilization, particularly in the post-acute sector, have led to a myriad of statutory and regulatory initiatives including the passage of the IMPACT Act in 2014 and the development and impending implementation of the Patient Driven Payment Model (PDPM) and Patient Driven Groupings Model (PDGM) in the skilled nursing facility and home health sectors respectively. While many policymakers believe that increased or inappropriate utilization is a result of fraud, too little attention is paid to the impact of policy choices as a driver of changing utilization in different settings. CMS should not make policy changes without fully considering all drivers of utilization trends.

For example, current law requires that 60% of patients admitted to inpatient rehabilitation facilities (IRFs) have one of 13 conditions. This policy choice, designed in part to "control" IRF utilization, contributes significantly to increased utilization in SNFs. It is inappropriate and inaccurate to attribute utilization changes in SNFs solely to fraud and unnecessary over-utilization when specific policy choices were clear factors in these utilization trends.

Address specific policies or requirements that are overly burdensome, not achievable, or cause unintended consequences in a rural setting

Physician Orders for Audiology Services
By statute, Medicare currently covers only diagnostic services provided by an audiologist and does not cover treatment services furnished by these health care professionals. As discussed above, Medicare also imposes an administrative burden on beneficiaries seeking audiology services by mandating that they obtain a physician referral for coverage. ASHA supports legislation in Congress to expand Medicare coverage to include all covered diagnostic and treatment services that correspond to an audiologist's scope of practice. Allowing audiologists to treat patients within their full scope of practice and without a physician's order would streamline access to care for Medicare beneficiaries, particular those in rural areas who may have to travel long distances to see a physician for an order, then see the audiologist for assessment of their condition and then return to a physician or other health care provider for their treatment. These policies are not imposed by other payers and puts Medicare beneficiaries in rural areas under burdens not faced by other Americans. ASHA looks forward to working with CMS and Congress to alleviate these unnecessary burdens.

Network Adequacy Standards
Maintenance of adequate provider networks is critical to ensuring timely access to care for patients. While there is some effort required for health plans to document and ensure the accuracy of their network's adequacy, that effort is far outweighed by the benefit of such information to the consumer. Beneficiaries have a right to a clear understanding of how they can access the care that they have signed up for upon enrollment in a particular health plan.

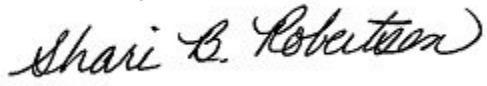
Additionally, clinicians such as audiologists and SLPs, applying to become Medicaid providers may be denied the ability to become an enrolled provider because individual plans choose to establish particularly narrow networks or state there are an adequate number of providers in that area when that is often inaccurate. Continued oversight is necessary to ensure that provider directories are kept current and adequately reflect provider specialties needed to address specific conditions. A beneficiary faces an undue burden when they must travel long distances or experience long waits for services when networks do not maintain a sufficient number of providers. As noted above, the GAO has already found CMS oversight of provider networks deficient. Therefore, ASHA reiterates our request for CMS to provide greater oversight of all aspects of managed care compliance with federal requirements including ensuring provider network information, specifically regarding Medicaid managed care plans, is accurate and adequate to meet patient needs.

Thank you for your consideration of our recommendations. ASHA remains committed to improving access to care for all patients in need of our members' services. In summary, they include:

- eliminating the burdensome and unnecessary requirement for physician certification and recertification of the plan of care for Part B therapy services;
- implementing a notice of election (NOE) for home health services to prevent unnecessary denials of therapy services delivered to Part A Medicare beneficiaries as a result of consolidated billing;
- streamlining Medicare quality reporting requirements across Parts A and B;
- requiring direct supervision of students providing therapy services as opposed to 100% personal supervision for outpatient services;
- reviewing existing guidance or proposing further guidance to reduce administrative barriers to providing and obtaining reimbursement under Medicaid for health care services provided in school settings;
- developing a transparent oversight process for Medicare and Medicaid managed care companies;
- drawing attention to problematic aspects of Medicaid work requirements;
- using HIPAA authority to ensure accurate and efficient coding across payers;
- publishing RVUs for all CPT codes to ensure payer compliance with coding recommendations;
- convening stakeholders to develop consistent quality reporting requirements across different payers;
- recognizing nonphysician providers for technology-based communication services;
- issuing explicit guidance on beneficiary liability when Medicare statutory and regulatory requirements are not met;
- recognizing the role of policy choices as a driver of utilization trends;
- working collaboratively with policymakers to allow for direct access to audiology services by removing language requiring a physician referral;
- drawing attention to problematic aspects of Medicaid work requirements; and
- ensuring network adequacy standards are developed and enforced.

Thank you for your consideration of these comments. If you or your staff have questions, please contact Sarah Warren, ASHA's director for health care policy for Medicare, at swarren@asha.org.

Sincerely,



Shari B. Robertson, PhD, CCC-SLP
2019 ASHA President

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