



September 11, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator, Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS–1784–P  
P.O. Box 8016  
7500 Security Boulevard  
Baltimore, MD 21244–8016

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Medicare Physician Fee Schedule (MPFS) proposed rule and requests for information for calendar year (CY) 2024.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students.

ASHA's comments focus on several key areas including:

- Determination of Practice Expense (PE) Relative Value Units (RVUs) (Section II.B.)
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (Section II.D.)
- Valuation of Specific Codes (Section II.E.)
- Evaluation and Management (E/M) Visits (Section II.F.)
- A Social Determinants of Health Risk Assessment in the Annual Wellness Visit (Section II.S.)
- Updates to the Quality Payment Program (Section IV.)
- Audiologists Furnishing Certain Diagnostic Tests Without a Physician Order

### **Determination of Practice Expense (PE) Relative Value Units (RVUs) (Section II.B.)**

#### **Adjusting RVUs To Match the PE Share of the Medicare Economic Index (MEI)**

ASHA appreciates CMS's proposal to continue postponing implementation of the updated MEI weights pending the outcome of the American Medical Association's (AMA's) work to gather data that more accurately reflects physician practice expenses. In addition, a group of nonphysician qualified health care professionals are also working to collect real-world data that reflects the practice expenses for these professionals to share with CMS using the same methodology and contractor employed by the AMA. ASHA is part of this group and is committed to providing CMS with representative data regarding the cost to run audiology and speech-

language pathology practices. ASHA strongly believes this is an important effort to ensure MPFS payments are accurate, which ultimately maintains access to care for Medicare beneficiaries and protects the Medicare trust fund.

**PE RVU Methodology: Low Volume Service Codes**

ASHA also appreciates CMS’s ongoing efforts to improve the stability of PE and malpractice (MP) RVUs for low volume services. We agree with the proposal to use service-level overrides for low-volume services to help mitigate annual fluctuations and provide greater stability in the valuation of these services. Several low-volume services provided by audiologists have been particularly susceptible to large fluctuations in PE RVUs and, as such, **we provide comments on the proposed specialty overrides for those services in the following table.**

CPT Code	Descriptor	CY 2024 Anticipated Specialty	ASHA Comment
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	Otolaryngology	Agree
92518	ocular (oVEMP)	Otolaryngology	Agree
92519	cVEMP and oVEMP	Otolaryngology	Agree
92572	Staggered spondaic word test	Audiologist	Agree
92596	Ear protector attenuation measurements	Audiologist	Agree
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	Audiologist	Agree
92602	subsequent reprogramming	Audiologist	Agree
92621	Evaluation of central auditory function, with report; each additional 15 minutes	Audiologist	Agree
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	Audiologist	Agree

**Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (Section II.D.)**

**Implementation of the Consolidated Appropriations Act of 2023**

ASHA appreciates CMS’s efforts to implement the requirements of the Consolidated Appropriations Act, 2023 (CAA; P.L. 117-328) by extending telehealth coverage through December 31, 2024, for services provided by audiologists and SLPs by maintaining coverage of all existing CPT codes on the telehealth services list. In addition, **ASHA requests CMS to add new CPT codes 9X015, 9X016, and 9X017 (caregiver training services without the patient present, provided under a therapy plan of care) to the telehealth services list for CY 2024.**

We believe that there are scenarios where caregiver training may be provided via telehealth—particularly with patients who are being discharged from a facility into a home—to train caregivers when modifications to activities of daily living or functional techniques may be necessary to aid in the safe transfer to their home. ASHA provides the following scenario as an example of an effective use of caregiver training, without the patient present, via telehealth.

A patient with a history of multiple sclerosis and diagnosis of pharyngeal dysphagia has difficulties with swallowing. The patient is being discharged from a skilled nursing facility (SNF) to a community dwelling at their adult child's home in a different city. The patient's plan of care included skilled speech-language pathology services to improve swallow safety with the use of correct positioning and appropriate swallowing strategies. The patient will be discharged on a modified diet of pureed foods with mildly thick liquids. The patient is unable to independently meal prep but can independently communicate dietary needs and meal preferences. Prior to discharge from skilled speech-language pathology services at the SNF, the SLP provides caregiver training to the patient's adult child via telehealth. This session focuses on demonstrating how to modify meals to pureed foods and mildly thick liquid consistencies, at appropriate temperatures. Direct (one-on-one) skills training is also provided to the caregiver for meal set-up, use of cueing to ensure patient's use of safe swallow strategies, and meal set-up to ensure patient's successful participation in mealtimes.

ASHA also appreciates the maintenance of coverage for all practice settings billing services under the MPFS including institutional providers such as SNFs and hospital outpatient departments (HOPDs) through December 31, 2024.

While CMS has expressed concern that it does not have the statutory authority to pay for telehealth services provided in institutional settings, to date, it has not provided guidance regarding deficiencies in the CAA that would preclude coverage for these services. ASHA remains steadfast in our assertion that the CAA provides the legal authority necessary to continue to cover these services when provided by institutional providers and paid under the MPFS. Specifically, as it relates to HOPD services, Chapter 6 of the Medicare Benefit Policy Manual recognizes that physical and occupational therapy and speech-language pathology services are exempt from the outpatient prospective payment system (OPPS) and, instead, are paid under the MPFS. While these services are usually billed on the UB04 claim form rather than the 1500 claim form, given how the services are paid, ASHA does not believe that the claim form itself should make a difference. ASHA acknowledges that the flexibility to register a patient's home as a temporary extension site and consider those services to be "in-person" rather than virtual (as part of the Hospitals Without Walls flexibilities) may have expired with the end of the public health emergency (PHE), but that flexibility is separate from the ability of an HOPD to bill for telehealth services.

More importantly, the CAA gives CMS the authority necessary to maintain access to telehealth services provided by facility-based therapists when paid for under the MPFS. For example, while section 4140 appears to focus on extending acute hospital care at home waivers and flexibilities, it lists the various waivers that are extended through 2024 to include (C), which states:

"Waiver of the telehealth requirements under clause (i) of section 1834(m)(4)(C), as amended by section 4113(a) of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening

Public Health Act of 2022, such that the originating sites described in clause (ii) of such section shall include the home or temporary residence of the individual.”

This statement seems to address telehealth services provided under the MPFS by hospital-based therapists.

Further, the CAA extends the existing telehealth flexibilities through 2024 in section 4113 to include the following sites:

- (I) The office of a physician or practitioner
- (II) A critical access hospital
- (III) A rural health clinic
- (IV) A Federally qualified health center
- (V) A hospital
- (VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites)
- (VII) A skilled nursing facility
- (VIII) A community mental health center
- (IX) A renal dialysis facility
- (X) The home of an individual
- (XI) A rural emergency hospital

The site listings provided seem to extend the ability to provide telehealth services by a variety of providers, including facility-based providers, when the services are billed under the MPFS. In addition, the CCA provisions affirm that occupational therapists, physical therapists, and SLPs are authorized telehealth providers through 2024. Given that 63% of outpatient therapy services paid under the MPFS are provided by institutional practitioners, failing to include these settings in telehealth coverage policies jeopardizes Medicare beneficiaries' access to care.

Therefore, ASHA recommends that CMS:

1. Identify the deficiency in the CAA that precludes it from applying telehealth coverage flexibilities to institutional providers;
2. Maintain coverage for authorized telehealth services through December 31, 2024, when provided by audiologists or SLPs in institutional settings;
3. Adopt its proposal to maintain coverage for outpatient audiology and speech-language pathology services through December 31, 2024, as authorized by the CAA; and
4. Add the caregiver training codes to the authorized telehealth services list on a provisional basis.

#### **Proposed Steps of Analysis for Services Under Consideration for Addition, or Removal, or a Change in Status, as Updates to the Medicare Telehealth Services List**

ASHA appreciates CMS's efforts to clarify the process it will undertake as it assesses proposals to add telehealth services to the list in future years. ASHA supports the proposal to maintain the two categories for approval and applying the concept of permanent or provisional in approving a service for addition to the list.

However, in reviewing the 5-step process for approving codes for addition to the authorized telehealth services list, ASHA requests clarification regarding step 5. The proposal states that the evidence submitted must demonstrate that the clinical benefit of the telehealth service is “analogous” to the in-person benefit, which seems to indicate that the service must be of the same or similar quality and outcomes as when provided in person. However, in the same description of the Step 5 criteria, CMS states, “We remind readers that our evidentiary standard of demonstrated clinical benefit does not include minor or incidental benefits (81 FR 80194) and, if finalized, our proposal would not alter or displace this longstanding requirement.”

**ASHA requests that CMS clarify the standard by which a code request will be evaluated under Step 5.** It is not clear if the quality and clinical benefit need to be the same regardless of whether the service is provided in person or via telehealth. Nor is it clear if it is CMS’s expectation that the telehealth service clinical benefit has to exceed the benefit of an in-person service. ASHA recommends that the clinical benefit of a telehealth service should be comparable to, or the same or similar as, an in-person service and it should not have to demonstrate additional or more clinical benefit regardless of whether that benefit could be construed as substantial or minor or incidental.

### **Place of Service (POS) for Medicare Telehealth Services**

ASHA applauds CMS’s acknowledgement that “practitioners will typically need to maintain both an in-person practice setting and a robust telehealth setting...[and] we expect that these practitioners will be functionally maintaining all of their PEs, while furnishing services via telehealth.” ASHA has long asserted that audiologists and SLPs providing telehealth services often also provide in-person services and, as a result, the costs to run a practice do not significantly change based on mode of service delivery. According to a 2023 survey of ASHA members, 72% of respondents reported that brick and mortar costs (e.g., rent and utilities) remain a business expense and 68% provide similar materials (e.g., written or licensed digital materials, testing tools, treatment tools) to in-person and telehealth patients.<sup>1</sup> **Therefore, ASHA strongly supports CMS’s proposal to pay claims billed with POS 10 (Telehealth Provided in Patient’s Home) at the non-facility rate.**

In addition, CMS proposes that claims billed with POS 02 (Telehealth Provided Other than in the Patient’s Home) will continue to be paid at the facility rate. However, services paid under the MPFS that are billed by physical therapy, occupational therapy, and speech-language pathology are always paid at the non-facility rate, regardless of the setting. **As such, ASHA requests CMS clarify whether telehealth services billed by therapy providers in a facility setting and reported with POS 02 will be paid at the facility or non-facility rate.**

### **Clarifications for Remote Monitoring Services**

ASHA supports CMS’s ongoing work to identify communication technology-based services (CTBS), including remote monitoring services, which promotes greater access to care for Medicare beneficiaries. As part of this work, CMS implemented the family of remote therapeutic monitoring (RTM) services under the 2022 MPFS for reporting by physicians and nonphysician qualified health care professionals (QHPs), including SLPs. SLPs may report the RTM codes for home-based voice or swallowing training devices that provide biofeedback to the patient and produce objective data for the clinician, allowing the clinician to provide ongoing adjustments to training exercises and informing the plan of care and treatment goals. SLPs may also conduct remote monitoring through mobile applications or computer-based software used to design a personalized home training program supplementing speech, language, and/or cognitive

treatment and allowing the clinician to collect objective data regarding the patient's functional performance and progress.

In this rule, CMS proposes further clarifications regarding requirements for reporting both remote physiologic monitoring (RPM) and RTM services, including data collection requirements. ASHA is concerned by CMS's current proposal to clarify that, in order to report any service from the RTM code family, remote monitoring and data collection must have occurred for at least 16 days in a 30-day period. CMS states that it had originally discussed this requirement in the 2021 MPFS; however, the RTM codes did not exist at that time. In addition, CMS did not discuss this requirement when the RTM family of codes was implemented in the 2022 MPFS. Finally, CMS's proposed clarification does not align with the 2023 CPT Professional Edition codebook (CPT codebook), which clearly outlines in prefatory language and parentheses that the 16-day data collection requirement only applies to CPT codes 98975, 98976, 98977, and 98978. The CPT codebook does not apply this same requirement to CPT codes 98980 and 98981, which are valued based on the QHP's professional work and time spent reviewing and interpreting the data, as well as communicating the results and treatment recommendations to the patient and/or caregiver. Implementing a 16-day requirement on these codes—which are already based on the amount of time spent providing the service—adds a layer of unnecessary complexity for tracking the requirements for billing. **Therefore, ASHA urges CMS to align its reporting requirements to the CPT codebook by clarifying that the 16-day data collection minimum applies only to current and future PE-only CPT codes used for reporting the remote monitoring device and supplies, and *not* the treatment management codes (98980, 98981).**

#### **Valuation of Specific Codes (Section II.E.)**

---

##### **(18) Auditory Osseointegrated Device (AOD) Services (CPT Codes 926X1 and 926X2)**

ASHA appreciates and supports CMS's proposal to accept the RUC's recommended work RVUs and direct PE inputs for CPT codes 926X1 (Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes) and 926X2 (Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes [list separately in addition to code for primary procedure]). In addition, we agree with CMS's recommendation to add 926X1 and 926X2 to the list of audiology services that can be billed with the "AB" modifier, because AOD services are primarily provided by audiologists.

**ASHA urges CMS to finalize the proposed values for CPT codes 926X1 and 926X2 and add them to the list of audiology services that are billable with the "AB" modifier.**

##### **(26) Payment for Caregiver Training Services**

ASHA applauds CMS for its proposal to implement and separately pay for caregiver training services (CTS), including CPT codes 9X015, 9X016, and 9X017 for caregiver training services under a therapy plan of care established by a physical or occupational therapist (PT, OT) or an SLP. This proposal signals CMS's acknowledgement of the caregiver's critical role in supporting patient care and provides clinicians with the time and resources to engage caregivers more effectively as part of the individual patient's plan of care.

ASHA's following comments on caregiver training services focus on CPT codes 9X015, 9X016, and 9X017, which describe caregiver training without the patient present, as established under a therapy plan of care.

### *Definition of a Caregiver*

CMS broadly defines a caregiver as a “family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition.” CMS provides a more detailed definition of a caregiver—for the purposes of CTS—as an “individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long-term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis” and that a caregiver would include, but is not limited to, a legal guardian, who is a “layperson assisting the patient in carrying out a treatment plan”. **ASHA supports the definition CMS outlines in the context of CTS.**

### *Patients who Benefit from Care Involving Caregivers*

ASHA appreciates CMS’s discussion of patients who could benefit from care involving caregivers and agrees that there are a wide variety of clinical circumstances when it may be reasonable and necessary to train a caregiver who assists in specific activities to carry out a treatment plan. For example, caregiver training without the patient present may be particularly indicated for those patients who are unable to consistently participate in their care due to their medical status (e.g., cognitive deficits, communication deficits, challenging behaviors, fluctuations in physical capacity or activity tolerance) or for patients with a planned discharge to home from an acute or post-acute care setting who require preparatory caregiver instruction for the home environment.

CMS also seeks feedback regarding the potential for duplicative payment under another benefit category or federal program, including Medicaid. ASHA agrees with CMS’s assessment that CTS, as outlined in the proposed rule, is a very specific service and will not overlap with any other services covered for dually eligible Medicare and Medicaid beneficiaries. In addition, ASHA is not aware of states covering similar services under their Medicaid programs.

### *Reasonable and Necessary CTS*

ASHA agrees that CTS is reasonable and necessary when it is provided under an established, individualized plan of care. However, CMS requests comment regarding billing for CTS for all the caregivers of a patient under CPT code 9X017. While ASHA agrees that billing for any of the CTS codes should only occur once per patient for any of the base CTS therapy codes, it is important to note that CPT code 9X017 for group caregiver training is designed to report those times when the caregiver(s) of *multiple patients* are present, not for when there are multiple caregivers of a *single patient*. In those cases where one or more caregivers of a *single patient* receive CTS, CPT codes 9X015 and 9X016 should be reported based on the amount of time spent with the caregiver(s) of that patient, not based on how many caregivers are present. If caregiver(s) of *multiple patients* participate in CTS together, then the clinician would bill 9X017 for group caregiver training once *per patient represented*, not once per caregiver. **ASHA reiterates that all billing for 9X015, 9X016, and 9X017 should be based on the patient and is not based on how many caregivers are present.**

### *Proposals*

ASHA supports CMS’s proposal to establish active payment status for all the CTS codes discussed in the rule, including CPT codes 9X015, 9X016, and 9X017 (caregiver training services under a therapy plan of care established by a PT, OT, or SLP). **ASHA affirms that 9X015, 9X016, and 9X017 reflect the professional work, time, and practice expense of**

**PTs, OTs, and SLPs, and thus, are most appropriate for billing reasonable and necessary CTS under a therapy plan of care.**

As discussed earlier, ASHA agrees with CMS's proposal that payment be made for CTS under the MPFS when the treating QHP identifies the need for CTS for one or more caregivers in the treatment plan. In addition, ASHA supports the proposed definition of a caregiver in the context of CTS as a "layperson assisting the patient in carrying out a treatment plan." CMS also proposes to require the treating QHP to obtain the patient's (or patient's representative's) consent when CTS is furnished outside the patient's presence, and that the consent must be documented in the medical record. ASHA notes that, as with all aspects of care, the treatment plan is developed in collaboration with the patient and/or their legal representative/guardian, which aligns with CMS's proposal to require consent for CTS when provided without the patient present.

**ASHA urges CMS to finalize payment for reasonable and necessary CTS, including 9X015, 9X016, and 9X017 for CTS provided under a therapy plan of care.**

In addition, ASHA recommends CMS add 9X015, 9X016, and 9X017 to the CY 2024 list of temporary telehealth services. Please refer to our telehealth discussion on page 2 above for ASHA's rationale.

*Coding and Valuation for Caregiver Training in Strategies and Techniques to Facilitate the Patient's Functional Performance (CPT codes 9X015, 9X016, 9X017)*

ASHA appreciates and supports CMS's proposal to accept the RUC's recommended work RVUs and direct PE inputs for CPT codes 9X015, 9X016, and 9X017. In addition, we agree with CMS's recommendation to designate 9X015, 9X016, and 9X017 as "sometimes therapy" codes.

**ASHA urges CMS to finalize the proposed values for CPT codes 9X015, 9X016, and 9X017 and designate them as "sometimes therapy" codes.**

However, CMS indicated that the RUC recommendation for 9X017 (group CTS) is based on the median group size for five *caregivers*. It is important to clarify that the value recommended by the RUC is based on five *patients represented*. As discussed earlier, these codes are all based on the patient rather than how many caregivers are present.

**Evaluation and Management (E/M) Visits (Section II.F.)**

---

**Office/Outpatient (O/O) E/M Visit Complexity Add-On Implementation**

In the 2021 MPFS final rule, CMS finalized implementation of updated E/M codes for office and outpatient services and a new add-on code, G2211, for visit complexity inherent to O/O E/M services. Due to required budget neutrality adjustments, these policies would have resulted in devastating payment cuts for those specialties who cannot report E/M services, including audiologists and SLPs. Congress recognized the harm these cuts would cause to provider practices and Medicare beneficiary access to care and passed the Consolidated Appropriations Act, 2021 (CAA; P.L. 116-260), which mitigated, but did not eliminate, the impact of these cuts, including postponing implementation of G2211 through 2023.

Because the Congressional pause on G2211 expires at the end of 2023, CMS again proposes to implement the add-on code in 2024. Although ASHA recognizes CMS's efforts to refine its utilization assumptions from those that were made in 2021, we also note that G2211 accounts



for approximately 90% of the budget neutrality adjustment, which will result in an estimated 3% decrease in the conversion factor (CF) when compared to the 2023 CF. This adjustment disproportionately affects those provider groups, including audiologists and SLPs, who cannot report E/M related services, and have experienced annual payment cuts since CMS implemented the updated O/O E/M codes in 2021. In addition, ASHA believes that G2211 is ill-defined and overlaps with work that is already captured in other codes paid under the MPFS. If implemented, the add-on code could result in overpayment that only compounds the underlying issues with the Medicare payment system, including placing an undue burden on providers and Medicare beneficiaries, who must shoulder the impact of the program's budget neutrality mandate.

**Therefore, ASHA urges CMS to stop implementation of G2211.** Canceling this policy would allow CMS to apply those savings to the budget neutrality calculation and lessen the negative impact to affected providers.

### **A Social Determinants of Health Risk Assessment in the Annual Wellness Visit (Section II.S.)**

---

ASHA agrees that social determinants of health (SDOH)—or the nonmedical factors such as where people are born, live, learn, work, play, worship, and age—affect a wide range of health, functioning, and quality-of-life outcomes and risks. The identification, documentation, and intervention of such factors is essential for equitable, high-quality, holistic, patient-centered care. In line with CMS's goal to transition virtually all Medicare and Medicaid beneficiaries into accountable care relationships by 2030, ASHA acknowledges the health equity implications of including SDOH risk assessments to risk adjustment in value-based payment systems.

ASHA supports the practice of early and holistic identification and treatment of upstream factors to improve downstream outcomes and costs. The cost of newly proposed G-codes for SDOH risk assessment can be balanced by potential long-term benefits and savings resulting from appropriate holistic interventions that have direct impacts on patient health outcomes and future health care utilization.

This proposed rule suggests adding the SDOH risk assessment to annual wellness visits. While this is helpful, ASHA suggests that other nonphysician qualified health providers, such as audiologists and SLPs, are strongly positioned through both frequency of patient contact, strong rapport, practice in a variety of settings, and specialization in communication to obtain essential SDOH information that patients may be reticent to share.

Audiologists and SLPs typically see patients for multiple visits during an episode of care. They may treat patients in acute, inpatient, outpatient, skilled nursing, home health, or private practice settings. Many of these settings allow direct observation of non-medical factors impacting a patient's health. Due to patient communication impairments, SLPs often build strong working relationships with families and caregivers who can provide valuable information for an SDOH risk assessment. During the course of treatment, as communication improves, patients often share personal information of challenges to their recovery including SDOH risk factors with their audiologist or SLP. **Therefore, ASHA recommends expanding the SDOH risk assessment service and associated G-code (GXXX5) to nonphysician qualified health care providers who cannot report E/M services.** This would also reinforce the value CMS places on addressing SDOH, as demonstrated by its proposal to adopt new Merit-Based Incentive Payment System (MIPS) measures in the audiology and speech-language pathology specialty measure sets.

In addition, as the national association with a vision of “making effective communication, a human right, accessible and achievable for all,” ASHA recognizes communication as not only a critical health outcome, but also a social determinant of health impacting the effectiveness of other health interventions and a range of health care, economic, and social factors.

## **Updates to the Quality Payment Program (Section IV.)**

---

### **A. Merit-Based Incentive Payment System (MIPS)**

#### *1. Audiology and Speech-Language Pathology Specialty Measure Sets*

In this proposed rule, CMS adds two measures to the audiology specialty measure set:

- *Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:* Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive.
- *Connection to Community Service Provider:* Percent of patients 18 years or older who screen positive for one or more of the following health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their HRSNs within 60 days after screening.

ASHA strongly supports the application of measures, such as the connection to community service provider, to a variety of clinical specialties including audiologists. Addressing social determinants of health, such as food or housing insecurity, is important to improving quality of life and outcomes for patients. **ASHA recommends CMS finalize this measure in the audiology specialty measure set.**

To reinforce CMS’s commitment to addressing SDOH and improving outcomes of care for Medicare beneficiaries, ASHA recommends CMS authorize audiologists to bill for a new SDOH assessment code as discussed in more detail above on page 9 of our comments.

However, ASHA does not support including the blood pressure screening measure. Audiologists could take a blood pressure reading with an electronic cuff procured from a medical device supplier and could even note when the blood pressure is high. But they are not clinicians in a position to manage and make recommendations to the patient regarding high blood pressure other than recommending the patient see a physician. Audiologists cannot prescribe medications of any kind—including blood pressure medications—in any state based on their scope of practice and licensing laws. ASHA is concerned that this would potentially create increased administrative burden and liability for a clinical specialty with limited ability to address a high blood pressure reading. **Therefore, ASHA does not support its inclusion in the audiology specialty measure set for performance year 2024.**

In addition, CMS proposes adding three measures to the speech-language pathology measure set including:

- *Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson’s Disease:* Percentage of all patients with a diagnosis of Parkinson’s Disease (PD) who were assessed for cognitive impairment or dysfunction once during the measurement period.

- *Screening for Social Drivers of Health*: Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
- *Connection to Community Service Provider*: Percent of patients 18 years or older who screen positive for one or more of the following health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their HRSNs within 60 days after screening.

As noted above, ASHA is supportive of measures designed to address SDOH. To reinforce this support, ASHA respectfully requests that CMS include SLPs as authorized billers of a new SDOH assessment code as discussed above on page 9 of these comments.

ASHA also specifically requested application of the assessment of cognitive impairment or dysfunction for patients with Parkinson's Disease and screening for social drivers of health measures in response to a request for information submitted in February 2023. **ASHA appreciates CMS accepting two of our recommendations and we encourage you to finalize these additions to the speech-language pathology measure set.**

We would also like to reinforce our support for adding the following additional measures to the speech-language pathology specialty measure set as noted in our response to the request for information in February 2023. ASHA looks forward to a continued partnership with CMS to develop a robust specialty measure set for SLPs.

- Measure 281: Dementia: Cognitive Assessment
- Measure 282: Dementia: Functional Status Assessment
- Measure 283: Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management
- Measure 286: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia
- Measure 288: Dementia: Education and Support of Caregivers for Patients with Dementia
- Measure 293: Rehabilitative Therapy Referral for Patients with Parkinson's Disease
- Measure 386: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences

## 2. *Application of the Promoting Interoperability Performance Category to Audiologists and SLPs in 2024*

During the CY 2023 rulemaking cycle, CMS suggested it would end the exemption from the promoting interoperability performance category for a variety of clinical specialties, including audiologists and SLPs, as early as 2024. It noted that for a large variety of clinical specialties, including audiologists and SLPs (approximately 16,000 individual clinicians), reporting on this performance category was 19% in 2019, not at all in 2020, and 7% in 2021.

In response to this suggestion, ASHA raised concerns that applying this performance category to audiologists and SLPs—given the limited reporting in the previous three years—was premature. Additionally, several requirements of this performance category, such as e-prescribing, are not applicable to nonphysician clinicians (e.g., audiologists, SLPs) and that requiring application for an exemption to these reporting requirements creates an inappropriate administrative burden. Additionally, very few electronic health record products used by

audiologists and SLPs have been certified, which might put ASHA members in the position of implementing—at great personal expense—a product that does not meet their needs simply for the purposes of complying with MIPS.

Finally, in a review of the CY 2023 final rule, ASHA did not see any language that would finalize the end of the promoting interoperability exemption for audiologists and SLPs as early as 2024. And in the CY 2024 proposed rule, CMS specifically exempts social workers from this performance category but is silent on other categories of clinicians. The lack of a clear policy in either the final rule for 2023 or the proposed rule for 2024 creates a significant level of confusion for a variety of clinical specialties.

**As a result, ASHA continues to recommend that CMS maintain an exemption to the promoting interoperability category for audiologists and SLPs for 2024, until these important concerns are addressed.**

If CMS does end the exemption from the promoting interoperability performance category in a future year, there should be a minimum of one year's notice to enable those previously exempt adequate time to identify and procure a certified product. Specifically, the timing of the final rule's release in November 2023 would not allow ASHA members sufficient time to be in compliance by January 1, 2024. Therefore, CMS should definitively state it is ending the exemption for a performance year (e.g., 2025) in the previous year's final rule (e.g., 2024) to allow sufficient time to meet the requirements.

### ***B. Advanced Alternative Payment Models (APMs)***

#### *Proposals To Align CEHRT Requirements for Shared Savings Program ACOs With MIPS*

ASHA broadly supports the priorities of the Quality Payment Program including achieving more equitable outcomes; utilizing clinically relevant measures for specialty performance that inform clinicians and beneficiaries; and enhancing quality, patient safety, and efficiency through use of certified electronic health record (EHR) technology (CEHRT).

ASHA applauds the flexibility allowed by amending the definition of CEHRT to what is most clinically relevant, beginning with CY 2024. By including any EHR technology certified under the Office of the National Coordinator for Health IT (ONC) Certification Program that meets: (1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR 170.102); and (2) any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM for the year, administrative burden, provider frustration, and inefficiencies will be reduced.

However, ASHA is concerned with the proposal to no longer specify a minimum number of eligible clinicians that an Advanced APM must require to use CEHRT and, instead, simply specify that the Advanced APM must require all participating eligible clinicians to use CEHRT that meets the proposed modified and more flexible definition. This could have the unintended consequence of limiting nonphysician qualified health care professional participation in APMs due to financial constraints. The initial financial outlay for EHRs can be cumbersome and advance investment payments (AIPs) tend to focus on physicians. **ASHA recommends either maintaining a 75% threshold for the number of clinicians using CEHRT or ensuring that advance investment payments are applied to all members of the care team, not only managing physicians.**

### *Qualified Participant (QP) Determinations*

CMS proposes to end the use of APM Entity-Level QP determinations and instead make all QP determinations at the individual eligible clinician level to ensure no accountable care organization (ACO) participant receives a disproportionate financial benefit compared to the amount of care provided. As a professional organization representing nonphysician qualified health professionals, very few of ASHA's members are eligible to participate in the Medicare Shared Savings Program (MSSP). Those who are eligible typically qualify through their affiliation with larger health systems. ASHA is concerned that a change of QP determination to the individual provider level could increase administrative burden while further inhibiting our members from participating in the program. Such actions may impede the care coordination and interprofessional collaborative practice goals of APMs that will lead to better care, healthier communities, and reduced spending. **Therefore, ASHA suggests that it would be premature to move to individual determinations from entity determinations.**

### *Expanding the Health Equity Adjustment to Medicare CQMs*

ASHA agrees with CMS's proposal to support ACOs in their transition to electronic clinical quality measures (eCQMs)/MIPS CQMs by proposing that ACOs that report Medicare CQMs would be eligible for the health equity adjustment to their quality performance category score when calculating shared savings payments.

*Cherry picking* refers to carefully selecting a caseload of the mostly healthy, uncomplicated patients who are the more likely to have good outcomes with the least amount of intervention; thereby, making these patients a "low" financial risk and "high" payment opportunity.

Conversely, *lemon dropping* occurs when providers are disincentivized from treating patients with one or more SDOH risk factors such as economic instability and lack of access to education and quality health care—including preventative care—leading to chronic conditions, multiple comorbidities, and disabilities in underserved populations. Such patients often require more services, are challenging to manage clinically, require a longer length of stay, and might be more costly. Their risk factors might incorrectly skew a facility's quality scores or measure denominators when these patients are excluded from the measure.

In a value-based payment system, identification of and payment adjustment for SDOH are essential because patients with fewer SDOH risk factors become more "attractive" to providers since they will likely have better outcomes and require fewer services and resources as compared to their "riskier" counterparts, despite similar clinical characteristics. This adjustment is necessary to correct the unintended consequence of disincentivizing the care of underserved populations in value-based payment systems.

### *MIPS Value Pathway (MVP) Reporting for Specialists in Shared Savings Program ACOs—Request for Information (RFI)*

ASHA appreciates the RFI on the role of specialty reporting in MVP that acknowledges that ACOs cannot be successful without a strong yet flexible integration of specialists. ASHA argues that nonphysician qualified health care professionals, such as audiologists and SLPs, play an integral role in the health outcomes and functional independence of a patient as part of a collaborative interprofessional team that includes primary care physicians and specialists and should be further integrated into value-based care systems.

**ASHA recommends financially incentivizing the collection of MVP data that is most relevant to their clinician practice for *all* care team members to ensure a holistic and accurate view of health outcomes and quality.**

***C. Quality of Care for the Treatment of Ear, Nose and Throat Disorders MIPS-Value Pathway (MVP)***

CMS proposes a new MVP - Quality Care for the Treatment of Ear, Nose, and Throat Disorders. The MVP is aimed to focus on providing care for patients experiencing some of the most common otolaryngology conditions such as, but not limited to, otologic conditions, chronic rhinosinusitis (CRS), age-related hearing loss (ARHL), and otitis media. CMS suggests this proposed MVP would be most applicable to clinicians who treat patients within the practice of otolaryngology, including nonphysician qualified health providers such as audiologists, nurse practitioners, and physician assistants. **ASHA respectfully urges CMS to remove audiologists from this MVP.**

Audiologists are not classified as practitioners under Medicare. Audiology is limited to the **diagnostic-only** areas of hearing and balance health care. Under the MVP, CMS proposes to include eight MIPS quality measures and four QCDR measures within the quality performance category of this MVP, which promote the management and care associated with otolaryngology. **Each of the proposed measures listed below are outside the scope of practice of audiology. Audiologists are the professionals to whom patients are referred for evaluation of hearing loss; therefore, measures tied to referring patients for comprehensive audiologic evaluation are in scope for referring physicians, not audiologists themselves.**

- *Q277: Sleep Apnea: Severity Assessment at Initial Diagnosis:* This MIPS quality measure ensures adults diagnosed with obstructive sleep apnea have an apnea hypopnea index (AHI), a respiratory disturbance index (RDI), or a respiratory event index (REI) documented or measured within 2 months of initial evaluation for suspected obstructive sleep apnea.
- *Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse):* This overuse MIPS quality measure assesses for prescribed antibiotics within 10 days after the onset of symptoms for those patients diagnosed with acute viral sinusitis.
- *Q332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):* This appropriate use MIPS quality measure ensures patients diagnosed with acute bacterial sinusitis are prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.
- *Q355: Unplanned Reoperation within the 30 Day Postoperative Period:* This MIPS quality measure evaluates for an unplanned reoperation within 30 days of a denominator eligible procedure
- *Q357: Surgical Site Infection (SSI):* This MIPS quality measure evaluates for SSI within 30 days of a denominator eligible procedure.
- *AAO20: Tympanostomy Tubes: Comprehensive Audiometric Evaluation:* This MIPS quality measure ensures pediatric patients diagnosed with otitis media with effusion (OME) receive tympanostomy tube insertion and a comprehensive audiometric evaluation within 6 months prior to tympanostomy tube insertion.
- *AAO21: Otitis Media with Effusion (OME): Comprehensive Audiometric Evaluation for Chronic OME > or = 3 months:* This MIPS quality measure ensures pediatric patients

diagnosed with otitis media with effusion (OME) including chronic serous, mucoid, or nonsuppurative OME of > or = 3 months duration receive an order or referral for comprehensive audiometric evaluation.

- *AAO23: Allergic Rhinitis: Intranasal Corticosteroids or Oral Antihistamines:* This MIPS quality measure ensures patients 2 years and older with a diagnosis of allergic rhinitis are prescribed or recommended intranasal corticosteroids (INS) or non-sedating oral antihistamines. In addition, we are proposing to include the following broadly applicable MIPS quality measures that are relevant to otolaryngology. The quality measures below assess for age specific screenings, and follow-up actions for select measures:
- *Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:* This MIPS quality measure assesses patients, aged 18 years and older, for a BMI documented with a follow-up plan documented if their most recent documented BMI was outside of normal parameters.
- *AAO16: Age-Related Hearing Loss: Comprehensive Audiometric Evaluation:* This MIPS quality measure ensures patients aged 60 years and older who have failed a hearing screening and/or who report suspected hearing loss receive, are ordered, or referred for comprehensive audiometric evaluation.

The only proposed measures that audiologists can currently report are:

- *Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:* This MIPS quality measure screens patients for tobacco use. Any patients that are found to be tobacco users should receive tobacco cessation intervention.
- *Q487: Screening for Social Drivers of Health:* This MIPS quality measure ensures adults are screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

CMS proposes to include one MIPS cost measure within the cost performance category of this MVP, which applies to the clinical topic of otolaryngology. CMS suggests the following cost measure provides a meaningful assessment of the clinical care for clinicians who specialize in otolaryngology care and aligns with the other measures and activities within this MVP:

- *Medicare Spending Per Beneficiary (MSPB) Clinician:* This MIPS cost measure applies to clinicians providing care in inpatient hospitals, including otolaryngologic care.

CMS notes it aligns with the surgical measures within this MVP, *including Q355: Unplanned Reoperation within the 30 Day Postoperative Period and Q357: Surgical Site Infection (SSI)*. Again, this measure is outside the scope of practice of audiology.

### **Audiologists Furnishing Certain Diagnostic Tests Without a Physician Order**

With the exception of adding the auditory osseointegrated device codes to the list of services that can be billed with an “AB” modifier, CMS does not propose any changes to the policy, which allows audiologists to provide assessment services without a physician order in limited circumstances (e.g., nonacute hearing assessments once per 12-calendar months per Medicare beneficiary). ASHA supports adding these two CPT codes to the list. ASHA also appreciates that CMS identified that it had the administrative authority to remove the physician order requirement for audiology services and we welcome an opportunity to partner with CMS to improve the policy over time.

In analyzing additional data to demonstrate the appropriateness of allowing audiologists to provide hearing and balance assessment services to Medicare beneficiaries without a physician order, ASHA has identified several studies that further reinforce the need to update this policy. In one study, 95% of the patient participants who were evaluated for hearing loss required audiology services only and did not require any physician services. Audiologist treatment plans did not differ substantially from otolaryngologist plans for the same condition, there was no convincing evidence that audiologists missed significant symptoms of otologic disease, and there was strong evidence that audiologists referred to otolaryngology when appropriate. Overall, the researchers determined that improved access to audiology services did not result in harm to patients.<sup>2</sup>

A second study was conducted to determine whether patients within an otolaryngology department presenting with asymmetrical sensorineural hearing loss and/or unilateral tinnitus could be safely and cost-efficiently screened for acoustic neuroma by audiologists as a first or only point of contact. Over the course of the four-year study, the patient participants were screened for acoustic neuroma with magnetic resonance imaging, based on pre-determined criteria. Only 2% of the patients in the study were found to have an acoustic neuroma and were appropriately referred to the otolaryngologist for further assessment. The remaining patients were managed and discharged by the audiologists without ENT input, which resulted in cost savings.<sup>3</sup>

As discussed in detail in our comments to the 2023 MPFS proposed rule, we remain concerned that CMS has implemented this policy in such a narrow manner. As currently constructed, it does not recognize the full scope of practice of audiologists who are trained, qualified, and licensed to provide both hearing and balance assessment services (as well as treatment services, though we acknowledge federal law currently restricts Medicare coverage to audiologic assessment). In addition, the concept of non-acute hearing assessment services makes the policy challenging to implement and the restriction to once every 12 calendar months makes the policy administratively burdensome for patients, physicians, and audiologists. The restriction to once every 12-calendar months also fails to take into consideration the needs of patients—particularly patients who might need ototoxic monitoring during cancer treatment or cochlear implant programming or reprogramming over the course of a year.

Finally, CMS justified the development of the narrow policy based on a variety of program integrity and patient safety concerns. ASHA provided significant evidence in response to the 2023 proposed rule that existing program integrity mechanisms already deployed by CMS could address these concerns and challenged the notion that audiologists were unwilling or incapable of coordinating with a patient's physician. ASHA provided documentation demonstrating the low incidence of fraud, waste, abuse, and patient harm caused by audiologists to support that the policy should be expanded but this evidence was not substantively addressed by CMS in the 2023 final rule. ASHA is concerned that a narrow policy only serves to restrict timely access to care for Medicare beneficiaries and costs the Medicare trust fund more money, with little evidence to justify its construction.



We have summarized CMS’s stated concerns and outlined the program integrity tools that CMS has in place and can address those concerns, as discussed in detail in our 2023 comments, for your reference below.

CMS Concern	Solution
Care Coordination	<ul style="list-style-type: none"> <li>• Standards of practice</li> <li>• Ethical standards</li> </ul>
Fraud, Waste, and Abuse	<ul style="list-style-type: none"> <li>• State Board of Examiners data<sup>4</sup></li> </ul>
Unqualified Providers	<ul style="list-style-type: none"> <li>• State Board of Examiners data</li> </ul>
Order Ensures Medical Necessity	<ul style="list-style-type: none"> <li>• Orders not always helpful</li> <li>• Orders not always needed based on clinical needs of the patient</li> <li>• Place on claim form for the referring physician’s NPI</li> </ul>
Nonparticipating Providers and Balance Billing	<ul style="list-style-type: none"> <li>• Limiting charge</li> <li>• Prohibition on opting out</li> </ul>
Limited Beneficiary Financial Exposure	<ul style="list-style-type: none"> <li>• Services provided without an order can be billed directly to patient with an ABN</li> <li>• Need for an order increases beneficiary liability</li> </ul>
Reassigning Benefits to Business/Practice	<ul style="list-style-type: none"> <li>• NPI of rendering provider required on claims</li> </ul>
Mitigating Patient Harm	<ul style="list-style-type: none"> <li>• Low malpractice expense values</li> <li>• State Board of Examiners data</li> </ul>

**As a result, ASHA respectfully requests that CMS reconsider the audiology access policy finalized in 2023.** CMS has acknowledged significant implementation issues that led to denials earlier this year and guidance around documenting non-acute hearing loss creates additional and unnecessary administrative burden for audiologists. As constructed, the policy is challenging to use, and many ASHA members indicate they continue to get an order to avoid denials. ASHA believes that limited use of the policy might lead to inaccurate assumptions about the need or utility of such a policy when, in fact, the opposite is true. Given the significant impact hearing and balance disorders have on a patient’s quality of life and the cost that these untreated conditions can impose on the overall health care system, timely access to audiology services is more critical than ever. For your reference, ASHA is repeating our recommendations from the 2023 rulemaking cycle below and we hope CMS will seriously consider implementing these improvements as soon as practicable.

- CMS should include all hearing and balance assessments in this policy (not just nonacute hearing assessments);
- CMS should not restrict this proposal to once every 12-calendar months, as it jeopardizes access to care for select patient populations such as patients with cochlear implants; and
- CMS should use the program integrity tools at its disposal to ensure patient safety.

Thank you for your attention to our recommendations. If you have questions regarding our comments on MIPS, audiology access, or telehealth, please contact Sarah Warren, MA, ASHA’s

director for health care policy for Medicare at [swarren@asha.org](mailto:swarren@asha.org). If you have questions regarding our comments on CPT coding, please contact Neela Swanson, ASHA's director of health care and education policy, at [nswanson@asha.org](mailto:nswanson@asha.org). If you have questions regarding our comments on SDOH and A-APMs, please contact Rebecca Bowen, ASHA's director for value and innovation, at [rbowen@asha.org](mailto:rbowen@asha.org).

Sincerely,



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

---

<sup>1</sup> American Speech-Language-Hearing Association. (2022 April). *ASHA Member Survey, Coverage and Reimbursement for Telepractice Services*.

<sup>2</sup> Zapala, D.A., Stamper, G.C., Shelfer J.S., Walker, D.A., Karatayli-Ozgursoy, S., Ozgursoy, O.B., Hawkins, D.B. *Safety of audiology direct access for Medicare patients complaining of impaired hearing*. J Am Acad Audiol. 2010 Jun;21(6):365-79. doi: 10.3766/jaaa.21.6.2. PMID: 20701834.

<sup>3</sup> Abbas, Y., Smith, G., Trinidad, A. *Audiologist-led screening of acoustic neuromas in patients with asymmetrical sensorineural hearing loss and/or unilateral tinnitus: our experience in 1126 patients*. J Laryngol Otol. 2018 Sep;132(9):786-789. doi: 10.1017/S0022215118001561. Epub 2018 Sep 10. PMID: 30198461.

<sup>4</sup> National Council of State Boards of Examiners for Speech-Language Pathology and Audiology. (Summer 2022). *Licensure: An Official Publication of the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology*. <https://www.ncsb.info/resources/newsletter/archive/2022-summer.pdf>.