



January 25, 2022

Submitted to <https://www.regulations.gov/>

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (CMS-9911-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to comment on the 2023 Notice of Benefit and Payment Parameters proposed rule and its impact on health care consumers and providers through changes in federal requirements associated with the Affordable Care Act (P.L. 111-148).

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 218,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA and the Centers for Medicare & Medicaid Services (CMS) share a goal to improve health care coverage. While supportive of the majority of what CMS has proposed, ASHA offers specific comments on the following topics:

- Provision of Essential Health Benefits
- Quality Improvement Strategies to Address Health and Health Care Disparities
- Prohibition on Discrimination
- Visit Limitations
- Standardized Options
- Network Adequacy
- Cost Sharing

Provision of Essential Health Benefits (45 CFR Part 156.115)

ASHA strongly supports CMS's proposal to prohibit benefit substitution between Essential Health Benefits (EHB) categories. The allowance of between-category substitutions could weaken the habilitative and rehabilitative services and devices benefit category, thereby limiting or preventing access to medically necessary services. Each benefit category was included in the Affordable Care Act (ACA) provision of EHB to ensure a comprehensive and appropriate collection of benefits that meets a patient's needs across the lifespan.

The EHB category of habilitative and rehabilitative services and devices is most important to ASHA and patients who require habilitative and rehabilitative care. Prior to the passage of the ACA, private insurance had very limited coverage of habilitative services and devices. Following the enactment of the ACA and subsequent regulations, there was a significant increase in coverage of habilitative services among ACA compliant plans and across the entire private health insurance market as non-ACA plans were influenced by the EHB mandate.

ASHA remains concerned with the allowance of within-category substitution. While ASHA has seen no examples of problematic substitution within the rehabilitative and habilitative services and devices category, ASHA is concerned that health plans may inappropriately prioritize types of rehabilitative therapy in such a way that would reduce the comprehensive benefit for consumers. A further concern related to within-category substitution is device coverage. Limitations placed upon certain devices, such as hearing aids or speech-generating devices within the broad category of rehabilitative and habilitative devices may negatively impact consumer access to the critical rehabilitative and habilitative services and devices they require. CMS's requirement that habilitative services and devices be covered no less comprehensively than rehabilitative services and devices helps ensure an adequate balance of coverage, but substitution policies cause potential risk to some beneficiaries. ASHA will continue to monitor coverage policies to help ensure that flexibility for within-category substitution is only used to improve the benefit package for consumers.

Quality Improvement Strategies (QIS) to Address Health and Health Care Disparities (45 CFR part 156.1130)

ASHA is a strong proponent of diversity, equity, and inclusion and supports the addition of reducing health care disparities as a topic area for quality improvement in section 1311(g)(1) of the ACA. Meeting the specific needs of all individuals in the context of their social determinants of health is critical to ensuring that patients receive a high quality of care.

In the area of communication disorders, ASHA is focused on reducing health care disparities through targeted multimedia educational resources for clinicians, mentoring programs for underrepresented populations of students, and support of the Allied Health Workforce Diversity Act of 2021 (H.R. 3320/S. 1679).

Prohibition on Discrimination (45 CFR part 156.125)

ASHA supports nondiscriminatory benefit design and the use of relevant, clinically based, evidence to dispute a discriminatory benefit design claim. ASHA notes that CMS provided a list of journals and resources deemed reputable for the purposes of disputing discriminatory benefit design. However, ASHA urges CMS to clarify that its list was only illustrative of such clinical journals. ASHA recommends that CMS add ASHA's peer-reviewed journals to the existing examples (p. 664 of the proposed regulation) when moving forward with the final rule, including:

- American Journal of Audiology;
- American Journal of Speech-Language Pathology;
- Journal of Speech, Language, and Hearing Research
- Language, Speech, and Hearing Services in Schools, and;
- Perspectives.

ASHA supports the proposed provisions in § 156.200(e) of this rulemaking related to protecting individuals from discrimination based on sexual orientation and gender identity. ASHA

appreciates CMS's commitment to comprehensive gender affirming care, including voice and communication therapy. Specialty trained speech language pathologists (SLPs) are best equipped to facilitate overall vocal health and efficiency in addition to behavioral changes related to voice and communication for transgender people.¹²³ Incongruence between gender identity and voice/communication style may exacerbate gender dysphoria and decrease mental health and quality of life.⁴ Improving access to gender affirmation services (e.g., voice therapy) is a priority for ASHA in 2022 and beyond.⁵

Visit Limitations (45 CFR 156.125)

ASHA supports CMS's proposal to require that any limitations on services for EHBs be clinically based. Many of the existing limitations applied by exchange plans are arbitrary and negatively impact the most vulnerable patients. ASHA appreciates CMS's continued requirement that health plans apply any visit limitations separately to habilitation and rehabilitation services. We agree that any limitations should be clinically based and urge CMS to require that visit limitations, if any, be episode-based and not applicable on an annual basis. For example, the same visit limitations for speech-language pathology treatment of a stroke should not limit access to services if the patient has a subsequent car accident and requires speech treatment because of a traumatic brain injury. To further CMS's proposal to ensure that any visit limitations are clinically based, ASHA recommends that visit limits should not apply across multiple disciplines such as speech-language pathology and occupational or physical therapy. Patients should not have to choose whether they walk, talk, or eat because of arbitrary rehabilitation visit limits after suffering an injury or illness, such as stroke, that impairs multiple areas of function.

Standardized Options (45 CFR part 156.201)

ASHA understands the value of comparing similar or identical health plans to help consumers understand their coverage options; however, ASHA is concerned that special designation of standardized plans may mislead consumers by presenting the standardized plans as better than non-standard plans. Depending on a consumer's individual circumstances, either a standardized or non-standardized plan may be the most beneficial and effective for meeting their health care needs. If CMS designates standardized plans differently within the exchanges, ASHA recommends that CMS include a disclaimer clarifying what designates plans as standardized and note that non-standardized plans continue to provide comprehensive coverage as required under the law.

ASHA provides the following responses to certain comment requests enumerated on page 675 of the proposed regulation.

1. **Requiring FFE and SBE-FP issuers to offer standardized options at every product network type, metal level, and throughout every service area that they offer non-standardized options:** ASHA agrees that offering standardized options at every product network type, metal level, and throughout every service area that they offer non-standardized options could be beneficial to consumers.
2. **Not limiting the number of non-standardized options that issuers can offer through the Exchanges:** ASHA agrees that the number of non-standardized options that issuers can offer through the Exchanges should not be unnecessarily limited.
3. **The feasibility, advantages, and disadvantages of gradually limiting the number of plan options over the course of several PYs:** ASHA notes that limiting the number of plans over the course of several payment years should only be done within the lens of ensuring comprehensive affordable coverage.

4. **Whether standardized options should be differentially displayed on HealthCare.gov as well as the best manner for doing so ASHA has concerns that differently displaying standardized plans on Healthcare.gov may give consumers the erroneous impression that standardized plans represent the best, or most comprehensive, benefits package available:** ASHA recommends that CMS consider adding a disclaimer encouraging consumers to compare plans to determine the package best suited for their health care needs if CMS opts for a differential display of standardized plans.
5. **Whether web-brokers and issuers using the Classic DE and EDE Pathways should remain subject to differential display requirements:** ASHA agrees that holding standardized plans display requirements constant across web-brokers and issuers will be the most transparent and consumer-centric option.
6. N/A
7. **Exempting State Exchange issuers from these requirements:** For consumer transparency and ease of use, ASHA encourages CMS to maintain uniformity across state and federal exchange platforms.
8. **Whether these plan designs should apply to State Exchanges that do not use the Federal platform and that have not implemented their own standardized options:** Yes, these plan designs should apply to state exchanges that do not use the federal platform and have not implemented their own standardized options.
9. **Exempting FFE and SBE–FP issuers that are subject to existing state standardized options requirements under state action taking place on or before January 1, 2020 from being required to offer the standardized options in this proposal:** ASHA recommends that issuers should only be exempt from being required to offer the standardized options in this proposal if the state standardized option requirements provide greater transparency than those outlined in this proposal.
10. **The methodology used to design these standardized options:** ASHA urges CMS to be transparent in their methodology in a plain language manner to maximize consumer understanding.
11. -14. N/A

Standardization does not speak to whether the benefit package is better or worse than other non-standardized plans offered within the exchange. ASHA does not want consumers to choose a standardized plan mistakenly because of a perception that they represent more comprehensive coverage when that may, in fact, not be the case.

Network Adequacy Standards (45 CFR part 156.230)

ASHA thanks CMS for specifically including SLPs in CMS's network adequacy enforcement efforts (as listed in Table 18: Proposed Individual Provider Specialty List for Time and Distance Standards). ASHA recommends that CMS add audiologists to the time and distance standards as well. This addition is especially important and timely with the forthcoming availability of over-the-counter hearing aids. Raising awareness of audiologists' role in hearing health care helps improve consumer protection and safety as these new medical devices become available to the public.

In addition, ASHA encourages CMS to take a broader perspective on ensuring the availability of clinically appropriate post-acute care settings. ASHA recommends CMS consider the addition of comprehensive outpatient rehabilitation facilities (CORFs), long-term acute care hospitals (LTACHs), and inpatient rehabilitation facilities (IRFs) to Table 19 Proposed Facility Specialty

List for Time and Distance Standards or to include a broader post-acute care facility category inclusive of various types that can, together, meet patients' needs.

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

ASHA recommends that CMS urge health plans to utilize telehealth modifiers in order to more clearly identify and designate telehealth services, as well as to better understand telehealth utilization and coverage and how supplementing network adequacy standards with telehealth coverage could best meet consumer needs. Both the modifier 95, created by the American Medical Association through the Current Procedural Terminology (CPT) process, and the GT modifier, created by CMS, designate services as provided remotely via telehealth. Broader adoption of these modifiers affixed to CPT codes submitted on claims could lead to a better understanding of how telehealth is used to meet consumer needs.

Payment for Cost Sharing Reductions (45 CFR part 156.430)

ASHA appreciates that CMS has proposed to continue limiting cost sharing for therapy services to those provided by primary care as opposed to the more costly specialty category. However, ASHA notes that speech-language pathology and other therapy treatments often entail multiple visits per episode of care. Additionally, those who receive audiology and speech-language pathology services often receive multiple services. This may present a financial barrier to accessing the recommended plan of care when the primary care cost sharing applies. ASHA recommends limiting audiology cost-sharing to the primary care category as well. In addition, ASHA urges CMS to consider how to limit cost sharing for therapy consumers as a result of the multiple visits they typically require. One option is to apply cost sharing to on a "per episode" as opposed to "per visit" basis. A second option is to reduce cost sharing for therapy services to the lesser of primary care cost sharing or 20% of the cost of therapy services. . The 20% copayment currently applies to Medicare Part B services. Limiting cost sharing would improve affordability of care, particularly for *bronze* category patients who may well find \$50 copayments, multiple times a week for multiple weeks, to be prohibitive to accessing medically necessary care.

Thank you for proposing important changes to the Notice of Benefit Payment Parameters that will improve access to care for millions of Americans. ASHA appreciates the opportunity to provide comments on this proposed rule and offer suggestions for further improvement. If you or your staff have any questions, please contact Rebecca Bowen M.A., CCC-SLP, ASHA's director for health care policy, value, and innovation, at rbowen@asha.org.

Sincerely,



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

¹ Davies S., Papp, V.G., Antoni C. *Voice and communication change for gender nonconforming individuals: Giving Voice to the Person Inside*. Int J Transgenderism. 2015 Jul 3;16(3):117-59.

² Thornton, J. Working with the transgender voice: The role of the speech and language therapist. Sexologies. 2008 Oct;17(4):271-6.

³ Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., et al. *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, Version 7. Int J Transgenderism. 2012;13(4):165-232.

⁴ University of California: San Francisco. (2016). Deutsch, M. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. <https://transcare.ucsf.edu/guidelines>.

⁵ American Speech-Language-Hearing Association. (2022). *2022 Public Policy Agenda*. <https://www.asha.org/advocacy/2022-asha-public-policy-agenda/>.