



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

June 22, 2015

The Honorable Johnny Isakson
The Honorable Mark Warner
Co-Chairs
Senate Finance Committee
Chronic Care Working Group
Washington, DC 2051

Dear Senators Isakson and Warner:

The American Speech-Language-Hearing Association (ASHA) is pleased to submit the following comments to the Senate Finance Committee's Chronic Care Working Group and looks forward to working with you and your staff as you develop legislation to address chronic care management for Medicare beneficiaries. ASHA is the national professional, scientific, and credentialing association for 182,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Many of our members work with individuals who suffer from chronic conditions and will be impacted by any changes in addressing this population.

Speech-language pathologists work to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders in children and adults. For Medicare purposes, speech-language pathologists work with Medicare beneficiaries that have suffered from a stroke, traumatic brain injury, cancer, or neurodegenerative diseases, such as Parkinson's disease, multiple sclerosis, or Alzheimer's disease. Speech language-pathologists work in a variety of practice settings including both inpatient and outpatient care. Our members work with chronic care patients to maintain their current function and to prevent or slow further deterioration.

Hearing and balance disorders can be assessed, treated, and rehabilitated by an audiologist. Audiologists are health care professionals who provide patient centered care in the prevention, identification, diagnosis, and evidence-based treatment of hearing, balance, and other auditory disorders for people of all ages. Hearing and balance disorders are complex with medical, psychological, physical, social, educational, and employment implications. Currently under Medicare, audiologists are only recognized for diagnostic services to rule out a medical condition. Audiologists can play an instrumental role in managing chronic conditions associated with cancer, such as ototoxicity. Ototoxicity is damage to the ear caused by chemotherapy, which can lead to hearing and balance disorders.

General Comments

Definition of Chronic care

Chronic care covers a wide-spectrum of diseases and conditions, including heart disease, diabetes, and cancer. While these conditions represent the highest cost to the Medicare program,

we urge the Committee to ensure that care coordination for all those with chronic conditions are included in your discussions. Chronic care should also include degenerative diseases that can benefit from treatment but won't be cured. Timely access to rehabilitation, care coordination, and regulator monitoring of these diseases can prevent dramatic changes requiring expensive urgent care (e.g., hospitalizations, use of emergency departments). These conditions include—but are not limited—to multiple sclerosis, Parkinson's disease, and Alzheimer's disease.

Defining Outcomes

While the goal of any medical intervention is to improve the condition of the individual, we caution the Committee to carefully review how it will define positive patient outcomes. Individuals with degenerative disease may not see significant functional gains, but need therapy to maintain function, which will save money. For example, timely intervention for swallowing disorders may defer the need for tube feeding or prevent aspiration pneumonia, malnutrition, or dehydration. For other conditions, intervention and caregiver training can preserve the maximum level of independence and self-care and optimize safety.

Although rehospitalization is an important indicator, we urge the Committee to consider other patient outcomes as well, especially as it relates to chronic conditions associated with degenerative disorders. The *Jimmo v. Sebelius* decision supports preventing deterioration of people with degenerative conditions and chronic diseases by ensuring that skilled services designed to maintain function are provided.

Response to Working Group Questions

Improvements to Medicare Advantage for Patients Living With Multiple Chronic Conditions

ASHA recommends that the Working Group consider making changes to the copay structures of MA plans to ensure beneficiary compliance with plans of care and treatment follow-ups. Currently, CMS allows up to \$40/visit in copays for therapy services, which could deter patients with chronic conditions from accessing medically necessary treatment. For comparison purposes, the average copayment for Medicare Part B outpatient therapy is \$16 (based on Medicare fee schedule rate of \$80/session).

We suggest that the Working Group explore options, such as:

- Tiered copays that reward patients for seeking treatment
- No copays, or quarterly “preventative care visits”, which could incentivize patients to seek care before symptoms get worse.
- Ensure that patients are seeking services at the right time to manage care and proactively treat symptoms.

Reforms to Medicare's Current Fee-For Service Program That Incentivize Providers to Coordinate Care for Patients Living with Chronic Conditions

Care Coordination

The passage of the Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act of 2010 has stimulated new approaches, such as the medical home concept, to achieving better outcomes in primary care, especially for high-risk chronically ill and other at

risk populations. Improved inter-professional team work and team-based care play important roles in many new primary care approaches.

Audiologists and speech-language pathologists, along with other non-physician providers, work in teams that enhance health or recovery through care coordination. Speech-language pathologists work with Medicare beneficiaries identified with chronic conditions that require close monitoring and treatment of swallowing, cognition, and communications disorders. Speech-language pathologists collaborate with other qualified health care providers on the development and revision of patient centered plans of care, care transitions, as well as home and community based clinical service coordination. Audiologists provide coordinated care to diagnose and monitor hearing loss for cochlear implant recipients and patients requiring oncology services. Care coordination for the complex patients treated by audiologists and speech-language pathologists is critical to the overall health and ability for the patient to remain functionally independent.

Additionally, the recently passed Medicare Access and CHIP Reauthorization Act, has placed emphasis on care coordination and appropriately recognizes the role of non-physician providers by requiring CMS to develop “patient relationship” codes that distinguish the role of the providers.

Unfortunately, current CMS policies prohibit the use of care coordination codes by non-physician providers—even though they play an integral role in the care of the patient. In order to make care coordination fully functional, there needs to be recognition and payment for all members of the care coordination team.

Electronic health records (EHR) and the ability to share health information will be critical to any chronic care payment system. Unfortunately, non-physician providers are not provided with support to offset the high cost of implementing a fully integrated electronic platform. In addition, current CMS EHR requirements related to meaningful use are onerous and provide a disincentive for providers to adopt an electronic platform. Additional barriers, including lack of a standardized infrastructure requirements, make it nearly impossible for providers using different EHR programs to communicate electronically.

To improve care coordination ASHA recommends that the Working Group review the feasibility of:

- Developing consultation codes for specialists
 - This could be limited to one time/condition
- Allow non-physicians to bill care coordination codes
 - Therapists often see the patient more than the physician and could play an integral role in care coordination
- Ensure appropriate valuation of care coordination codes that reflect all aspects of care coordination
 - There should be one code for the care coordinator; a separate code should be created for other members of the care coordination team to reflect their care coordination involvement

- Provide incentives for all Medicare providers to adopt EHR technology
- Remove or modernize onerous administrative challenges to adopting EHR

Reassess Certain CMS Rules That Impact Access to Care and Impede Effective Service Delivery

Over the years, CMS has implemented rules that have made it more difficult to coordinate care and are ultimately costly for the beneficiary. Specifically, the SNF three day rule, the Multiple Procedure Payment Reduction for outpatient therapy services, and the classification of certain services in the Outpatient Prospective Payment System (OPPS) disincentivize efficient, coordinated care and should be reviewed to determine if they impede patient access to services.

Three Day Rule

CMS mandates a three-night hospital stay as a prerequisite for skilled nursing rehabilitation coverage. This is an onerous and costly rule, as it may increase costs for hospital stays that are not needed. In addition, if the requirement is not met, they may deny therapy treatment for chronic patients in need of outpatient therapy services. The three day rule is arbitrary and limits the ability of patients to get the right care, in the most appropriate setting at the right time. Several pieces of legislation and demonstration proposals are looking at removing arbitrary barriers to care such as the three day rule or the home-bound requirement for accessing home health care. ASHA encourages Congress to remove such restrictions.

Multiple Procedure Payment Reductions (MPPR) For Outpatient Therapy Services

As part of the American Taxpayer Relief Act of 2013, Congress applied a 50% multiple procedure payment reduction to outpatient therapy services. The MPPR is based on false assumptions that duplications exist in the practice expense portion of therapy codes billed on the same day. Unlike most current procedural terminology (CPT) codes, therapy codes include a practice expense for a typical visit, which expense is spread out among multiple codes because multiple services are provided to the patient. However, CPT recognized that services are billed through multiple codes and the AMA's Relative Value Update Committee (RUC) valued the existing codes accurately as to not include duplicative practice expense values to the codes. CMS has taken this policy to include all therapy services for the day, rather than take the reductions by provider type. This requirement restricts patient access to vital therapy services. Individuals with multiple chronic conditions are hit the hardest as it creates disincentives for facilities and clinics to schedule provider visits on the same day. This practice may lead to patients deferring needed care and suffering functional declines as a result.

Outpatient Prospective Payment System (OPPS)

Audiology services performed in hospital outpatient clinics are reimbursed through the OPPS. ASHA understands the goals and intent of the OPPS to package certain "ancillary" services in order to promote efficiency in hospital outpatient departments. However, an appreciably high percentage of audiology services are classified as "ancillary" services, that is, adjunctive to a primary service. There are services assigned an ancillary status indicator that are, by definition, primary audiology services, and classifying services as ancillary results in no reimbursement for the services provided in

audiology and ear, nose, and throat clinics. This does not promote efficient services. Instead it promotes multiple appointments for scheduling a patient on different dates, at an additional expense to the patient.

ASHA Request that the Working Group review these and other rules related to outpatient therapy to ascertain what barriers they create for beneficiaries with chronic illness and to develop policies that lift these barriers and allow for better access to care.

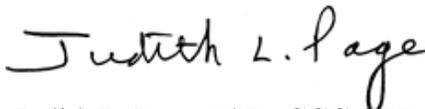
Ideas to Effectively Use or Improve the Use of Telehealth and Remote Monitoring

Research has confirmed that audiology and speech-language pathology services delivered via telehealth are comparable to those delivered face-to-face. Unfortunately, at this time, Medicare does not recognize audiologists and speech-language pathologists as eligible to receive reimbursement for providing services via telehealth.

ASHA recommends that the Committee include in any legislative language a provision that would recognize audiologists and speech-language pathologists as eligible to provide and receive reimbursement for telehealth services provided to Medicare beneficiaries. Not only would this allow beneficiaries who are confined to their home the ability to receive care, it would allow for greater access to chronic care coordination and management in rural and frontier areas, thereby reducing the need for later, more urgent intervention at a higher level of care.

Thank you for the opportunity to provide feedback to the Working Group. Please contact Ingrida Lulis, ASHA's director of federal and political advocacy, at ilulis@asha.org or 202-624-5951, if you require additional information.

Sincerely,



Judith L. Page, PhD, CCC-SLP
2015 ASHA President