ASHA
American
Speech-Language-Hearing
Association

Submitted via email: ProgramIntegrityRFI@cms.hhs.gov

November 19, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Information on the Future of Program Integrity

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Request for Information on the Future of Program Integrity.

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.

Our comments focus on ensuring the future of program integrity efforts meet the common goals of payers, clinicians, and patients to protect the system from improper payments while maintaining access to care for Medicare beneficiaries and minimizing clinician burden.

Questions on Program Integrity for Value-Based Payment Programs

1. **What type of opportunities for fraud, waste, and abuse do VBP arrangements present that are similar to or are different from FFS or managed care?**

   ASHA notes that all payers, including Medicare, need to run program integrity initiatives along two tracks because the transition to a value-based system from a volume-based system is still happening. ASHA appreciates that the question distinguishes between VBP and FFS since audiologists and speech-language pathologists (SLPs) often operate in a volume-based environment because many value-based models do not include audiology or speech-language pathology services. Therefore, ASHA agrees that program integrity efforts must address the potential for fraud, waste, and abuse in both the value-based and fee-for-service worlds simultaneously.

   An important distinction exists between value-based payment systems and value-influenced payment systems. In a value-influenced fee-for-service system, such as the Medicare Merit-Based Incentive Payment System (MIPS), the program integrity challenges remain the same as in the current volume-influenced system. Under MIPS, the incentive to provide a high volume of low-cost services to increase

reimbursement remains.

In a value-based payment system, the incentives relate to identification of "low-cost," or low resource use, patients that still garner high reimbursement. Program integrity should target ways by which clinicians or facilities "cherry-pick" patients. While a reduction in utilization and the identification of clinical efficiencies are goals of value-based arrangements. These goals do not supplant the obligation to ensure that the quality of care remains equal or surpasses that of volume-based payment systems. When implemented inappropriately, value-based arrangements put patients at risk of stinting on their care. To ensure that value-based arrangements deliver on their promise of maximizing patient care, they will need to include robust quality metrics and patient reported outcomes on the effectiveness and experience of care. Cost data on potentially preventable acquired health care conditions might also indicate stinting on care.

It's also important to consider that, when trying to align payments based on value and not volume for the purpose of improving payment accuracy, new and/or unintended incentives may be created that impact treatment decisions. Those incentives, rather than the clinician's professional judgment and expertise, may result in inappropriate payments and/or stinting on care. For example, recent implementation of the Patient-Driven Payment Model (PDPM) prospective payment system for skilled nursing facilities (SNFs) has highlighted that a well-intentioned effort to align payments based on patient characteristics instead of volume resulted in unanticipated administrative mandates within some SNFs that overrode clinical judgment. The administrative response to PDPM resulted in inappropriate productivity standards that ultimately weakened integrity of the program and quality of care for beneficiaries.

Questions on Prior Authorization in Medicare FFS

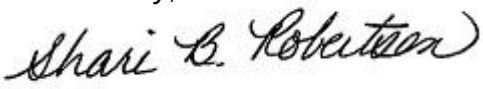
11. How can we apply prior authorization without adding to provider and supplier burden?

ASHA appreciates CMS's interest in establishing prior authorization for certain items or services. However, prior authorization is best used to identify high volume, low dollar services. One significant problem with application of prior authorization is that effectiveness relies on the appropriate resources to process the prior authorizations in a reasonable timeframe. For example, in 2006 and 2012, CMS used prior authorization to pay for speech-language pathology services over the medical review threshold of $3,700. In both instances, Medicare contractors did not process prior authorization requests in a timely fashion, sometimes taking in excess of 30 days to provide initial determinations to clinicians. This resulted in either delayed patient care or claim denials after the clinician had provided hours of treatment they saw as medically necessary. Such denials left clinicians without recourse for their lost reimbursement even though the statute required a specific response window that CMS never enforced on its contractors.

In addition, the foundational principles of prior authorization must include immediate or automatic exemptions for select conditions or circumstances that place a patient's health and/or life in serious jeopardy. Payers must establish and enforce clear prior authorization timelines for initial determinations and appeals. Clinician burden is significantly reduced when the documentation requirements for prior authorization requests are transparent through publicly available and clearly stated documentation requirements.

Thank you for considering ASHA's comments for this request for information. If you or your staff have questions, please contact Sarah Warren, MA, ASHA's director for health care policy, Medicare at swarren@asha.org.

Sincerely,



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