



September 3, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1809-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write in response to the outpatient hospital prospective payment system (OPPS) proposed rule for calendar year (CY) 2025.

ASHA is the national professional, scientific, and credentialing association for 234,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Audiologists and SLPs provide critical services to patients in hospital outpatient departments (HOPDs) and have a vested interest in ensuring that the payment system reflects the value of audiology and speech-language pathology services and supports access to care for Medicare beneficiaries.

X. Nonrecurring Policy Changes A. Remote Services

In this rule, CMS proposes to align telehealth coverage policies for Part B services—including speech-language pathology services—provided in HOPDs to those under the physician fee schedule to provide continuity of Part B coverage policies across settings. Telehealth coverage under Part B should not vary based on the type of facility from which Medicare beneficiaries access services. This would create confusion for providers and patients alike and unnecessarily restrict access to care. Therefore, ASHA requests that CMS finalize this policy to maintain consistency across settings.

X. Nonrecurring Policy Changes F. Request for Comment on Payment Adjustments Under the IPPS and OPPS for Domestic Personal Protective Equipment

CMS currently provides a payment adjustment to help hospitals offset the cost of personal protective equipment (PPE)—in particular, N95 respirators. In the proposed rule, CMS seeks feedback regarding whether it should allow additional forms of PPE to qualify for this payment adjustment, such as nitrile gloves.

Audiologists and SLPs working in HOPDs utilize various forms of PPE to protect themselves and their patients from transmission of illness. We appreciate CMS including N95 respirators under this payment adjustment and support the inclusion of nitrile gloves as well. In addition, ASHA recommends CMS consider face shields because SLPs performing instrumental swallow studies need to be protected from spit and phlegm that the patient might cough up during the evaluation. In addition, ASHA recommends CMS consider clear face masks to facilitate communication between audiologists and SLPs and their patients, particularly for patients who are deaf or hard of hearing and who may read lips to facilitate communication.

XIX. Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process

Current regulations require that HOPDs seek prior authorization from Medicare Administrative Contractors (MACs) for select services, including botulinum toxin injections (BTIs). SLPs are involved in the treatment of patients with voice disorders who may receive BTIs from their physician in addition to speech-language pathology services. We recognize the tremendous value of a comprehensive treatment approach and, as a result, are very interested in ensuring these patients maintain timely access to care.

In addition, ASHA has commented in response to several proposed rules issued by CMS designed to ensure prior authorization does not impose undue administrative burden on clinicians and facilities and does not jeopardize access to care for patients. We appreciate the Agency's efforts to date. In this rule, CMS proposes to align the non-urgent request determination timelines for HOPDs with those outlined in the interoperability and prior authorization final rule from 10 business days to seven calendar days. This should improve the timeliness of HOPD prior authorization requests, so they are delivered sooner, shortening the wait for patients to receive medically necessary care. CMS does not propose to change the expedited request timeline because of the chance that it could delay access to care for patients in emergent situations. ASHA appreciates that additional time is needed to consider making changes.

ASHA recommends CMS adopt its proposal to align the HOPD prior authorization timeframes with those outlined in the interoperability and prior authorization rule from 10 business days to seven calendar days.

XX. Provisions Related to Medicaid and the Children's Health Insurance Program (CHIP)

CMS proposes a change related to continuous eligibility for children ages 19 and under who are covered by Medicaid to implement a requirement of the Consolidated Appropriations Act (CAA) of 2023 (Public Law 117-328). Specifically, the proposal would require 12 months of continuous eligibility. For example, if a child qualified for Medicaid on July 1, 2024, and then in December 2024 they no longer met the state Medicaid eligibility requirements, the child would remain on Medicaid until June 30, 2025. ASHA is pleased with this proposed change, which is a positive and significant step towards maintaining access to and continuity of care for children covered under Medicaid.

XV. Hospital OQR Program

Health Equity Measures

ASHA supports the addition of the three health equity measures proposed under the Hospital Outpatient Quality Reporting (OQR) program, including the Hospital Commitment to Health Equity (HCHE) and Screening for Social Drivers and the Screen Positive Rate for Social Drivers of Health (SDOH) measures. We believe that robust data collection on patient demographics

and SDOH enables more accurate analysis of health equity and improves the quality of care for all beneficiaries in the Medicare program. ASHA agrees that 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' goal to transition virtually all Medicare and Medicaid beneficiaries into accountable care relationships by 2030, we see the importance of including SDOH assessment items in the OQR program to achieve greater health equity. We support the practice of early and holistic identification and treatment of upstream factors to improve downstream outcomes and costs.

Information Transfer PRO-PM

ASHA supports the addition of the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM).

Audiologists and SLPs are experts in communication and recognize how essential it is to verify that patients can hear, understand, and clarify post-procedure instructions. ASHA suggests that pre-procedure screening for communication disorders can help ensure post-operative instructions are in fact received and acted upon. As a standard of practice, pre-operative screenings could reinforce the intent of the proposed measure and improve patient outcomes. Pre-operative screening and appropriate referrals to audiologists and SLPs are upstream interventions that will prevent downstream complications and cost.

XXII. Modification to the Hybrid Hospital-Wide All-Cause Readmission and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measures in the Hospital Inpatient Quality Reporting Program

Audiologists and SLPs provide essential services related to balance, hearing, communication, cognition, and swallowing that improve functional status and help patients avoid rehospitalization.

Hearing loss, if left untreated, may lead to depression, anxiety, and emotional instability.¹ Results from a landmark 2023 study, the Aging and Cognitive Health Evaluation in Elders (ACHIEVE) study, revealed older adults with cardiovascular comorbidities and mild to moderate hearing loss yielded a 48% reduction in the rate of cognitive decline with hearing loss intervention.²

Individuals with untreated communication deficits are at risk for adverse outcomes—including poorer health, more chronic conditions, and increased health care costs.³ Without treatment, communication disorders impact a patient's ability to follow directions, communicate medical needs with providers and caregivers, and alert safety services in case of an emergency. Cognition impacts an individual's ability to manage medications, make reasonable personal safety decisions, and comply with home programs, which hinders the efficacy and efficiency of all other provided services. Untreated cognitive impairment is associated with potentially avoidable rehospitalization.⁴

Dysphagia—or difficulty swallowing—places patients at an elevated risk for malnutrition and dehydration, aspiration pneumonia, compromised general health, chronic lung disease, choking, and even death.⁵

While ASHA is in favor of adopting the Hybrid Hospital-Wide All-Cause Readmission and Standardized Mortality measure, we recognize the administrative and technical challenges with mandatory reporting at this time. Therefore, ASHA supports CMS' proposal that mandatory reporting wouldn't begin until FY 2027 payment determination (July 1, 2024 through June 30, 2025 performance period).

Thank you for considering ASHA's comments. For questions regarding our comments on quality reporting programs and measures, please contact Rebecca Bowen, MA, CCC-SLP, ASHA's director for health care policy, value, and innovation at rbowen@asha.org. For questions regarding proposals for Medicaid, please contact Caroline Bergner, JD, ASHA's director for health care policy, Medicaid, at cbergner@asha.org. For all other inquiries, please contact Sarah Warren, MA, ASHA's director for health care policy, Medicare, at swarren@asha.org.

Sincerely,



Tena L. McNamara, AuD, CCC-A/SLP
2024 ASHA President

¹ Gopinath, B., Hickson, L., Schneider, J., McMahon, C.M., Burlutsky, G., Leeder, S.R., & Mitchell, P. (September 2012). Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. *Age and Ageing*, Volume 41, Issue 5, Pages 618–623. <https://doi.org/10.1093/ageing/afs058>

² Lin, F. R., Pike, J. R., Albert, M. S., Arnold, M., Burgard, S., Chisholm, T., Couper, D., Deal, J.A., Goman, A. M., Glynn, N. W., Gmelin, T., Gravens-Mueller, L., Hayden, K. M., Huang, A. R., Knopman, D., Mitchell, C. M., Mosley, T., Pankow, J. S., Reed, N. S., Sanchez, V., ... Coresh, J. (2023). Hearing Intervention versus health education control to reduce cognitive decline in older adults with hearing loss in the USA (ACHIEVE): a multicentre, randomised controlled trial. *Lancet*. 402(10404), 786-797. <https://pubmed.ncbi.nlm.nih.gov/37478886/>

³ American Speech-Language-Hearing Association. (n.d.). *Communication Access: Better Health Starts with Effective Communication*. <https://www.asha.org/practice/communication-access/>

⁴ Mitsutake, S., Ishizaki, T., Tsuchiya-Ito, R., Furuta, K., Hatakeyama, A., Sugiyama, M., Toba, K., & Ito, H. (2021, March 31). Association of cognitive impairment severity with potentially avoidable readmissions: A retrospective cohort study of 8897 older patients. *Alzheimers Dement (Amst)*. 13(1):e12147. <https://doi.org/10.1002/dad2.12147>

⁵ American Speech-Language-Hearing Association. (n.d.). *Adult Dysphagia*. <https://www.asha.org/practice-portal/clinical-topics/adult-dysphagia/>