June 20, 2024

To the Patient Protection Commission,

As representatives of the Nevada Speech-Language Pathology and Audiology Association, we are writing to bring to your attention critical issues impacting the ability of private practitioners to provide quality care to patients in Nevada.

Speech pathologists provide essential services in the healthcare space across a variety of settings including hospitals, skilled nursing facilities, home health agencies, schools, and private practices. Services we provide include swallow imaging and treatment to rehabilitate those who are on a feeding tube or unable to eat, speech evaluation and treatment to aid children unable to articulate speech sounds, language evaluation and treatment for those post-stroke who have lost the ability to talk, voice prosthesis evaluation and treatment for patients post-laryngectomy who have no voice, speech-generating device evaluation and treatment for children with autism who are unable to communicate vocally, language evaluation and treatment for children who are delayed in communication, and evaluation and treatment for those who are Deaf and Hard of Hearing, which includes training in American Sign Language, aural rehabilitation, and auditory skills training. We work with pediatrics, adults and geriatrics. We work with clients diagnosed with Parkinson's disease, ALS (Lou Gehrig's Disease), stroke, brain injury, developmental disorders, head and neck cancer, autism, Down syndrome, and so many more. Each healthcare setting has a different reimbursement model per insurance guidelines. However, private practitioner speech pathologists have been experiencing considerable barriers that are negatively impacting our ability to provide these essential care and services.

The primary issue we urgently need your attention on is the stagnant and decreasing reimbursement rates for speech-language pathology services. Private practitioners cannot afford to remain in business under the current reimbursement models. Our reimbursement from insurers hasn't increased in 18+ years and has, in fact, *decreased* from many insurers. Reimbursement rates have failed to keep pace with inflation and the rising cost of living, forcing many private practitioners to close their businesses. For instance, the Medicaid reimbursement rate for CPT code 92507 (which covers treatment for speech, language, voice, communication, and auditory processing disorders) decreased to $66.16 from $93.29 around 2009 and has only further decreased to $63.64, where it has remained at the same amount for several years. Additionally, Medicare reimbursement rates have decreased annually for four years in a row, as a result of three separate statutory provisions designed to control federal spending: 1) budget neutrality, 2) statutory "Pay-As-You-Go" (PAYGO), and 3) sequestration. Advocacy by ASHA and other stakeholders helped lead to legislation postponing or mitigating these cuts since

2021. However, they will return in full in 2025 and will continue to be an annual issue without further Congressional action for both a short- and long-term fix. The rate for our main billing code (92507) was $81.20 in 2020 and is now currently at $74.98. These reductions mean we get paid less every year for each patient visit or diagnostic we provide, and many commercial insurers now use the Centers for Medicare and Medicaid (CMS) rates as the basis for establishing their own numbers (often determined as percentage). These rates fail to reflect our extensive scope of practice, educational level, ongoing training requirements, and the skills necessary to provide high-quality care to our patients. This financial strain not only jeopardizes the sustainability of our private practices, it undermines our ability to attract and retain qualified speech pathologists as they can make more money working in larger healthcare settings with alternative reimbursement models. Other providers leave the field altogether. These low rates are particularly egregious considering the quality of personalized care given in private practice settings versus large healthcare companies.

Additionally, private practices must comply with the same healthcare mandates as larger companies, resulting in numerous expenses that are non-reimbursable. For example, healthcare companies of any size are mandated to utilize electronic medical records. These records systems are expensive and their rates often increase annually. Fees are then added on to be able to use the billing code system required by law (CPT) and for each claim submitted. Private practices also must pay medical office rent that increases annually, and the accompanying insurance for liability and staff. Large companies often try to offset costs by increasing patient volume which can make productivity requirements high (and wholly unreasonable) and, in turn, limit the amount of time a practitioner can spend providing quality care (we've all heard stories of providers given only 15 minutes to meet, diagnose, treat a patient, AND document that encounter). Private practitioners, on the other hand, are required by some insurers to spend up to an hour with each patient in order to be able to bill for the service. This is positive in terms of patient outcomes, but negative as we are unable to increase patient volumes and, thus, reimbursement. We are not asking for ability to increase patient volume; we deal with medically fragile and complex patients that require accurate and skillful providers. We are asking for pay that is commensurate with our extensive scope of practice, education and training (entry level for our field is a master's degree), ongoing training requirements, overhead costs, regulatory costs, labor costs, and the quality that we provide. We beg you to consider: if your salary steadily decreased annually, would you be able to remain in your job?

Inadequate reimbursement doesn't only impact providers; it impacts the patients we serve. Limited provider networks result from many providers being unable to accept the low rates offered by insurance companies. Patients are supposed to have the right to choose their provider, but often cannot due to poor provider retention or being out of network with existing private practices. Patients must contend with long waitlists or long delays in necessary care. Delaying treatment can have severe consequences for patients, as early intervention following identification or diagnosis is crucial for maximizing brain plasticity, prognosis, and long-term success. Patients who are in-network with low-paying insurers and with no or high-deductible out-of-network benefits often have nowhere to go. Patients legally have the right to choose their provider, but often insurance barriers prevent access to those rights.

"We have [insurance company]. Their website boasts that they have a 'Commitment to Quality' which states that they 'are committed to' the following: "offering convenient access to quality health care providers…making sure you are satisfied with our services, providing responsive customer service" and that "when making a coverage decision, [insurance company's] medical and/or behavioral clinicians will consider not only evidence-based guidelines and the terms of your benefit plan, but also your unique clinical circumstances" – none of which they have done for us. Our provider network is largely unavailable and the only providers we were able to find without a long waitlist was told they could easily get an exception. This required multiple reconsiderations and the insurance company is still not even honoring the terms of the agreement, resulting in excessive administration time and costs for them, and constant follow-up for us. The providers are having to call on each claim and have them reprocessed two or three times for every visit. And each time we need a new authorization, the approval process is a repeat of the same arguments and efforts. They are constantly telling us we can see other providers in our network, but when I call, none of them are actually available. We've established such great relationships with our current providers and during a peer-to-peer call they made on our behalf were told 'convenience is not a factor.' We have more than two children needing services, so it's definitely a big factor for us. And their customer service is awful. We've tried to submit complaints to the Department of Insurance, but apparently it's outside of their jurisdiction because of our plan type. I'm not sure what to do. We have coverage but we can't use it." – Reno mother

We would be happy to provide many more statements in kind, should you like to read more testimonials from your constituents.

The second pressing issue is that both private practitioners and patients suffer from the lack of accountability for insurance payers. Payment delays, denials, and arbitrary restrictions imposed by insurance companies not only impede timely access to critical services but also create unnecessary administrative burdens for our practitioners. For example, providers often receive misinformation regarding patient eligibility and benefits, leading to claim denials and incorrect payments. When providers are not reimbursed accurately for services rendered, it not only affects their livelihood but also disrupts patient care. Patients may experience delays in receiving treatment, which impacts not only health but their developmental, social, and emotional outcomes. Insurers can deny services for a myriad of reasons including: "this treatment is deemed experimental by payer," "this diagnosis isn't covered," "this is not deemed a medical necessity by payer," "benefit maximum has been reached [maximums are set by payer]," "claim denied because benefit for this service in the allowance/payment of another service," "frequency of service not covered," none of which, frankly, should be determined by insurance payers. Denied claims can place a financial burden on patients, forcing them to pay out-of-pocket for essential services or abandon healthcare altogether. As mentioned above,

insurers require private practices to follow payer-specific rules for verifying patient benefits and eligibility, obtaining authorization for services (which is often denied), documenting services in electronic medical records, and billing provided services—all with various timelines and fine print. The administrative staff and time required to meet insurer rules is a heavy cost burden for private practitioners. Often we must call insurers and wait on the phone for hours getting answers for one patient alone. When services are denied, we have to spend additional time completing appeals or trying to convince insurers to cover medically necessary services. Insurers gatekeep services from patients, rather than entrusting clinical decision-making to those with the appropriate training and licensure to practice. Insurers also delay services for patients by requiring providers to complete authorization processes, which takes valuable time and is different for each payer. Authorization and claims processes often change, resulting in ongoing training with staff to try and comply with moving goalposts. When patients or providers don't follow insurer rules, they are penalized. But when insurers don't follow the rules, there are often no consequences for them. In fact, when payers make mistakes revealed in an audit, providers are penalized with recoupment of miscalculated payments. Frequently, claims billed correctly to insurers are often processed or paid incorrectly. This again increases cost burden on private practices who must then fight with insurers to correct claims – often more than once per claim. These administrative hurdles divert valuable time and resources away from direct patient care, ultimately hindering our ability to meet the needs of those who depend on us.

To address these issues, we urge you to take the following actions to ensure patients receive the care they need without unnecessary delays or obstacles:

1. Advocate for an immediate increase in Medicaid, Medicare, and private insurance reimbursement rates that accurately reflect the cost of providing services, inflation, skill level, and the increased cost of living.
2. Support legislation requiring annually increasing adjustments to reimbursement rates to account for inflation, skill level, and cost of living increases.
3. Encourage greater accountability from insurance companies by implementing measures to ensure the following:
    - accurate and timely information regarding patient eligibility and benefits
    - transparent reimbursement practices that support the No Surprises Act
    - reduce or eliminate prior authorization burdens for providers
    - a process for providers to hold payers accountable that includes penalizing insurers for incorrect claim processing

By improving reimbursement for private practitioners and increasing accountability of insurers, you can ensure that individuals with communication and swallowing disorders in Nevada receive the high-quality care they deserve. We ask that you include us in your future decision-making so that we can continue to provide valuable input on how to make lasting policy changes that benefit all Nevadans. We stand ready with you to improve these essential healthcare services.

Sincerely,

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