



American Speech-Language-Hearing Association
Statement for the Record for the House Committee on Ways & Means for the Hearing
on “Caring for Aging Americans”
November 25, 2019

Chairman Neal and Ranking Member Brady: The American Speech-Language-Hearing Association (ASHA) thanks you for the opportunity to submit this statement to the Committee, and is pleased that the Committee is examining important issues surrounding care for aging Americans, particularly relating to our vision of making effective communication accessible and achievable for all.

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.

Overview

Audiologists and speech-language pathologists (SLPs) are highly educated, trained, and certified health care professionals who are licensed in every state. They provide patient-centered care in the prevention, identification, diagnosis, and evidence-based treatment of hearing, balance, speech, language, cognitive-communication, and swallowing disorders in individuals of all ages.

ASHA members, including the more than 5,000 in Massachusetts and 14,000 in Texas, work in health care settings to help people learn, maintain, or improve skills and functional abilities that have not developed normally (habilitation), and to regain skills that have been impaired due to injury, illness, or condition(s) that have impacted normal functioning (rehabilitation).

Audiologists and SLPs provide services supporting the overall health and well-being of their patients to ensure older Americans can properly manage and/or avoid costly conditions or impairments that could impact their ability to effectively communicate and result in costly post-acute care (PAC).

Research conducted by the Johns Hopkins Bloomberg School of Public Health has found that “older adults with untreated hearing loss incur substantially higher total health care costs compared to those who don’t have hearing loss—an average of 46%, totaling \$22,434 per person over a decade.”¹ Since individuals with mild hearing loss are three times more likely to experience a fall, and falls are the leading cause of fatal injury for Americans over 65, early diagnosis and timely treatment of hearing and balance

impairments by audiologists helps older Americans avoid more serious and costly health care problems that undermine their quality of life. Seniors with hearing loss develop cognitive problems and experience cognitive decline up to 40% faster than those with normal hearing.^{2, 3, 4} Further, untreated hearing loss leads to depression, anxiety, and social isolation.⁵

Since Medicare is the primary federal program seniors rely on for health care, ensuring that statute and regulations provide sufficient reimbursement and efficient administration to allow clinically appropriate care to be provided at the proper time and in the right setting is of paramount importance.

Legislation in the 116th Congress

Several bills awaiting House action or consideration by the Ways & Means Committee would have a significant impact on older American's access to services provided by audiologists and SLPs.

Medicare Audiologist Access and Services Act (H.R. 4056)

Medicare precludes seniors from accessing the full range of services provided by audiologists in a timely manner by requiring a physician order and limiting reimbursement to diagnostic services only.

However, audiologists' scope of practice includes auditory and vestibular treatment and neurological monitoring. Medicare currently covers these treatment services when furnished by clinicians such as physicians or other nonphysician practitioners. In addition, most private health plans, Federal Employees Health Benefits (FEHB) Program plans, the U.S. Department of Veterans Affairs (VA), and some Medicare Advantage plans allow for direct access to audiology services, which is consistent with state laws.

The inability of most Medicare beneficiaries to receive both diagnostic and treatment services provided by an audiologist limits access to timely hearing health care and may increase health care costs. In fact, the National Academy of Sciences issued a report, *Hearing Health Care for Adults: Priorities for Improving Access and Affordability*, which recommended Medicare coverage of audiology treatment.⁶

To address these deficiencies, ASHA has endorsed H.R. 4056, *the Medicare Audiologist Access and Services Act*, introduced by Representative Tom Rice (R-SC) and cosponsored by five other members of the Ways & Means Committee. H.R. 4056 fixes these problems by enabling audiologists to provide both diagnostic and treatment services, allowing beneficiaries direct access to audiologists without a physician order, and reclassifying audiologists as practitioners under Medicare, which would allow these licensed health care professionals to provide telehealth services.

The Ways & Means Committee recently reported an amended version of H.R. 4618, the Medicare Hearing Act, sponsored by Representatives Lucy McBath (D-GA) and Debbie Dingell (D-MI), to include key provisions from H.R. 4056. ASHA appreciates and commends the Committee for working with the audiology stakeholder community to add these provisions, which provide coverage of audiology treatment services, address the classification of audiologists under Medicare, and authorize the U.S. Secretary of the Department of Health and Human Services (HHS) to allow direct access to audiologists. The improvements will help ensure a sufficient number of hearing health professionals to administer the bill's new hearing aid benefit for beneficiaries with severe to profound hearing loss.

ASHA urges House consideration of, and support for the Medicare Hearing Act (H.R. 4618)

CONNECT for Health Act (H.R. 4932)

Currently, Medicare does not allow audiologists and SLPs to deliver services via telehealth. However, both audiologists and SLPs are qualified providers of telehealth services and provide such services under many state laws and other payer policies, including Medicaid. Twenty states have included provisions in licensure laws that specifically authorize audiologists and SLPs to perform services via telehealth.⁷ Private insurers in 30 states have established policies that allow audiologists and SLPs to provide services via telehealth.⁸ In addition, 27 state Medicaid programs authorize these clinicians to perform services via telehealth.⁹

A growing body of research on the use of telepractice for communication disorders includes many studies demonstrating the comparability of telepractice and in-person services. For example, research conducted by the VA indicates that audiology services provided via telehealth are comparable to in-person delivery of care, while published studies also indicate that SLP services provided via telehealth are as effective as services provided in-person.^{10, 11, 12}

ASHA supports enabling audiologists and SLPs to provide telehealth services to Medicare beneficiaries when clinically appropriate and the ability of the clinician to ensure that the quality of any services provided via telehealth matches the quality of services provided in-person. Medicare coverage of audiology and speech-language pathology services would increase outlays by less than \$2.5 million over five years and less than \$10 million over 10 years.¹³

ASHA supports H.R. 4932, the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019, introduced by Representative Mike Thompson (D-CA), co-chair of the House Hearing Health Caucus, with original

cosponsorship of Representative David Schweikert (R-AZ). The bipartisan bill eliminates several barriers in Medicare that inhibit the ability of licensed health care professionals to provide telehealth services.

Specifically, H.R. 4932 authorizes the HHS Secretary to waive certain restrictions on telehealth services, including those related to the types of providers who can provide such services. It also would permit demonstration programs that could allow audiologists and SLPs—and other licensed health care professionals—to provide telehealth services to Medicare beneficiaries.

ASHA urges the Ways & Means Committee to schedule H.R. 4932 for consideration and amendment by Committee members.

Allied Health Workforce Diversity Act of 2019 (H.R. 3637)

The Bureau of Labor Statistics estimates that demand for audiology services will increase 21% by 2026 and the demand for speech-language pathology services will increase by 18% during that period. Consequently, there needs to be an adequate number of properly trained and diverse audiologists and SLPs to provide services to seniors, whether in-person or through telepractice.^{14, 15}

ASHA endorsed H.R. 3637, the Allied Health Workforce Diversity Act of 2019, introduced by Representatives Bobby Rush (D-IL) and Cathy McMorris Rodgers (R-WA). The bill, included in separate legislation (H.R. 2781) passed by the House, authorizes grants to accredited audiology and speech-language pathology programs at institutions of higher education to increase participation and retention of students from disadvantaged backgrounds, addressing provider shortages, and ensuring that the health care workforce mirrors the makeup of the overall population. A similar bill (S. 2747) was introduced in the Senate.

ASHA urges final action on these bills by the House and Senate.

Medicare Payment Policies

ASHA monitors Medicare payment policies that could have negative unintended consequences on the ability of seniors to receive timely medically necessary care provided by audiologists and SLPs in skilled nursing facilities, at home, and in certain PAC settings.

Patient-Driven Payment Model for Skilled Nursing Facilities

The Centers for Medicare & Medicaid Services (CMS) implemented the new prospective payment system for skilled nursing facilities (SNFs), the Patient-Driven Payment Model (PDPM), on October 1, 2019. PDPM bases payment on patient characteristics rather than

on the type and volume of services provided. CMS developed PDPM to address concerns of therapy overutilization to maximize reimbursement rather than meet patient needs under the previous payment system. ASHA supports improving payment accuracy by basing payments on individual patient characteristics rather than service volume. However, we are closely monitoring the impact of implementing PDPM to ensure Medicare beneficiaries in SNFs continue to receive clinically appropriate therapy services provided by SLPs.

ASHA is troubled by early reports from its members, and those from other therapy professions, about staffing reductions and changes in terms of employment that have been attributed to the new payment model. SLPs have also shared that they have been told the system requires group and concurrent therapy, establishes productivity requirements, and specifies which therapy professionals may provide care based on payment categories. None of these actions have basis in statute or regulation.

ASHA encourages the Committee to monitor ongoing implementation of PDPM and to request relevant CMS data to determine PDPM's impact on utilization relative to the previous payment model. Specifically, data on outcomes and quality improvement, hospital readmission rates, falls, and avoidable health conditions would be useful to determine the impact of PDPM implementation on Medicare beneficiaries' access to clinically appropriate care.

Patient-Driven Groupings Model for Home Health

ASHA is working to prepare its members for implementation of the new prospective payment system for home health care, the Patient-Driven Groupings Model (PDGM), on January 1, 2020. PDGM, similar to PDPM, will reimburse for care based on patient characteristics instead of the amount of therapy provided. Payments will be modified based on the source of admission (either from the community or from an institution), the presence of comorbidities, the patient's level of function, the time period within which services are provided, and the clinical grouping of the patient. Of the 12 clinical groupings established under PDGM, there are only two that would trigger therapy payments based on analysis of historic claims and assessment tool data.

Under the previous reimbursement system, the volume of services—such as speech-language treatment—triggered a separate payment. Under the new system, Medicare continues to expect that patients will still receive all the medically necessary services they need, regardless of whether the need triggers additional, therapy-specific payments. ASHA supports improving payment accuracy by moving from a volume-based system to one based on value in home health care, as long as home health agencies (HHAs) address all care needs included in the individualized home health plan of care, including the necessary disciplines to provide such care, as required by regulation.

ASHA is concerned that there appears to be a misunderstanding or manipulation of the structure of the clinical groupings, which could inadvertently lead to a restriction on the provision of therapy services if a therapy payment is not specifically included for the grouping. CMS has repeatedly attempted to correct the misunderstanding that could jeopardize beneficiary access to medically necessary care in this setting.

Specifically, the final 2020 PDGM rule, noted that “while these clinical groups represent the primary reason for home health services during a 30-day period of care, this does not mean that they represent the only reason for home health services . . . home health remains a multidisciplinary benefit and payment is bundled to cover all necessary home health services identified on the individualized home health plan of care. Therefore, regardless of the clinical group assignment, HHAs are required, in accordance with the home health CoPs at § 484.60(a)(2), to ensure that the individualized home health plan of care addresses all care needs, including the disciplines to provide such care. Under the PDGM, the clinical group is just one variable in the overall case-mix adjustment for a home health period of care.”¹⁶

ASHA encourages the Committee to monitor implementation of PDGM to ensure that patients receive the clinically indicated speech-language pathology services they need. Specifically, we urge the Committee to review data regarding admissions to home health from the community, rather than from hospitals, to determine if they significantly decrease given PDGM’s lower payment for such admissions. Without access to appropriate home health services, community residents might be forced to unnecessarily seek even more costly facility-based care. ASHA also recommends tracking data on the percentage of therapy provided within the first 30 days, or data that indicates the discharge of more patients within that period, because payment decreases during the second 30-day payment period under PDGM. Such information could indicate a restriction of access to medically necessary care for Medicare beneficiaries seeking or receiving home health services.

Improving Medicare Post-Acute Transformation (IMPACT) Act

Implementation of the Improving Medicare Post-Acute Transformation (IMPACT) Act also remains an issue of interest to ASHA. The IMPACT Act, as Ranking Member Brady highlighted in his opening statement, was designed to better understand differences in payments and outcomes in certain PAC settings with the goal of improving quality, discharge planning, and payment accuracy.

ASHA has provided information to CMS since enactment to ensure that standardized patient assessment data across the four PAC settings capture clinically relevant data that can improve the quality of care for Medicare beneficiaries, specifically regarding critical communication and cognition that directly impact the functional ability of patients admitted to and discharged from PAC settings. Unfortunately, CMS has not implemented sufficient assessment or quality measures related to communication and cognition to accurately

assess patient's functional status in these areas or to evaluate the quality of related therapy outcomes.

ASHA encourages continued oversight of the IMPACT Act and welcomes the opportunity to work with the Committee to ensure the collection of standardized assessment data and implementation of meaningful quality measures related to communication and cognition as required by the law.

Medicare Physician Fee Schedule (MPFS)

ASHA has raised concerns about proposed reductions in reimbursement for services provided by audiologists and SLPs, and their impact on seniors' access to care, outlined in the 2020 Medicare Physician Fee Schedule (MPFS) final rule.

As part of its 2020 MPFS final rule, released on November 15, 2019, CMS proposed to increase reimbursement for outpatient Evaluation and Management (E/M) codes for 2021. Unfortunately, CMS has proposed steep and seemingly arbitrary reductions to services furnished by physician and non-physician professionals. ASHA is alarmed by the potential scale of the estimated negative impact, given that audiologists and SLPs do not currently have access to E/M services as part of their Medicare benefit category to help potentially offset the projected reductions in 2021.

CMS has acknowledged the "magnitude of redistributive adjustment necessary to budget neutralize the increased values," while noting that future rulemaking would address the issue. ASHA encourages the Committee to engage with CMS to better understand the impact such cuts would have on seniors' access to medically necessary services and explore alternatives that could mitigate the negative impact of such reductions on audiologists and SLPs.

Conclusion

ASHA appreciates the Committee's attention to the complex issues surrounding care for aging Americans, especially those related to their ability to effectively communicate. We urge the Committee to act on the identified legislative initiatives, and monitor the highlighted payment issues, to ensure audiologists and SLPs can provide timely, quality, and clinically appropriate services to individuals throughout their lifespan in the proper setting.

Thank you for the opportunity to provide this statement for the record. ASHA looks forward to continuing to work with the Committee and Congress to ensure that aging Americans have meaningful access to the diagnostic and treatment services they need to make

effective communication accessible and achievable. For more information, contact Jerry White, ASHA's director of federal affairs, health care, at jwhite@asha.org.

¹ Reed, Nicholas S., et al. (2018). *Trends in Healthcare Costs and Utilization Associated with Untreated Hearing Loss Over 10 Years*. Retrieved from <https://www.jhsph.edu/news/news-releases/2018/patients-with-untreated-hearing-loss-incur-higher-health-care-costs-over-time.html>.

² Lin, Frank and Ferrucci, Luigi. (2012). *Hearing Loss and Falls Among Older Adults in the United States*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3518403/>.

³ Centers for Disease Control and Prevention. (2018). *Deaths from Falls Among Persons Aged ≥65 Years — United States, 2007–2016*. <https://www.cdc.gov/mmwr/volumes/67/wr/mm6718a1.htm>.

⁴ Lin, Frank and Yaffe, Kristine. (2013). *Journal of the American Medical Association: Hearing Loss and Cognitive Decline in Older Adults*. Retrieved from <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1558452>.

⁵ Oxford Academic. (2012). *Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later*. Retrieved from <https://academic.oup.com/ageing/article/41/5/618/47025/Hearing-impaired-adults-are-at-increased-risk-of>.

⁶ National Academies of Sciences Engineering Medicine. (2016). *Hearing Health Care for Adults: Priorities for Improving Access and Affordability*. Retrieved from <http://nationalacademies.org/hmd/reports/2016/Hearing-Health-Care-for-Adults.aspx>.

⁷ American Speech-Language-Hearing Association. Licensure Board Telepractice Requirements: Audiology and Speech-Language Pathology. Retrieved from <https://www.asha.org/uploadedFiles/Telepractice-Requirements-and-Reimbursement.pdf>.

⁸ American Speech-Language-Hearing Association. Private Insurance Laws and Regulations: Telepractice Reimbursement, Audiology and Speech-Language Pathology. Retrieved from <https://www.asha.org/uploadedFiles/Telepractice-Requirements-and-Reimbursement.pdf>.

⁹ American Speech-Language-Hearing Association. Medicaid Laws and Regulations: Telepractice Reimbursement, Audiology and Speech-Language Pathology. Retrieved from <https://www.asha.org/uploadedFiles/Telepractice-Requirements-and-Reimbursement.pdf>.

¹⁰ Gladden, Chad. (2013). *The Current Status of VA Audiology*. Retrieved from https://www.ncrar.research.va.gov/Education/Conf_2013/Documents/Gladden.pdf.

¹¹ Hayman M., Skinner L. and Wales D. (2017). *The Efficacy of Telehealth-Delivered Speech and Language Intervention for Primary School-Age Children: A Systematic Review*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5546562/>.

¹² Alvares Robin, Grogan-Johnson Sue, and Rowan Lynne. (2010). *A pilot study comparing the effectiveness of speech language therapy provided by telemedicine with conventional on-site therapy*. Retrieved from <https://journals.sagepub.com/doi/abs/10.1258/jtt.2009.090608>.

¹³ Quantria Strategies. (2015). ASHA Telehealth Cost Study. Analysis of a Proposal to Extend Telehealth to Audiology and Speech-Language Pathology Services. P. 3-4.

¹⁴ Bureau of Labor Statistics (2019). *Occupational Outlook Handbook: Audiologists*. Retrieved from <https://www.bls.gov/ooh/healthcare/audiologists.htm#tab-6>.

¹⁵ Bureau of Labor Statistics (2019). *Occupational Outlook Handbook: Speech-Language Pathologists*. Retrieved from <https://www.bls.gov/ooh/healthcare/speech-language-pathologists.htm#tab-6>.

¹⁶ Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements. November 8, 2019. [42 CFR parts 409, 414, 484, and 486]. Retrieved from <https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24026.pdf>.