ASHA
American
Speech-Language-Hearing
Association

December 3, 2020

Michael Chernew, PhD
Chairman
Medicare Payment Advisory Commission
425 I Street, NW
Suite 701
Washington, DC 20001

James E. Matthews, PhD
Executive Director
Medicare Payment Advisory Commission
425 I Street, NW
Suite 701
Washington, DC 20001

RE: Commission Development of Medicare Telehealth Reimbursement Recommendations

Dear Drs. Chernew and Matthews:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer recommendations on the work that the Medicare Payment Advisory Commission (MedPAC) is undertaking related to Medicare reimbursement for telehealth services. ASHA recognizes the longstanding work MedPAC has done on this issue as well as the increasing importance of telehealth during the federal public health emergency (PHE) due to the Coronavirus Disease 2019 (COVID-19).

ASHA is the national professional, scientific, and credentialing association for 211,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA appreciates the thoughtful consideration MedPAC Commissioners and staff have given to ensuring Medicare telehealth coverage facilitates access to health care services for Medicare beneficiaries while protecting them and the Medicare trust fund from inappropriate use of this service delivery mechanism. However, ASHA thinks some of the ideas under consideration have the potential to jeopardize access to telehealth services for Medicare beneficiaries.

ASHA's comments address the following areas:

1. evidence supporting the efficacy of audiology and speech-language pathology services provided via telehealth;
2. covered clinicians and patient populations;
3. reimbursement rates for telehealth services;
4. beneficiary cost sharing;
5. reinstating HIPAA requirements at the end of the PHE; and
6. establishing effective guardrails for the provision of telehealth services.

Evidence Supporting the Efficacy of Audiology and Speech-Language Pathology Services Provided Via Telehealth

Audiologists and speech-language pathologists (SLPs) are trained and qualified to provide telehealth services, which has been recognized by numerous states and payers. Prior to the PHE, more than 20 states had licensure laws authorizing audiologists and SLPs to provide telehealth services and many more have given them temporary authority during the pandemic. The Veterans Administration has also authorized audiologists and SLPs to provide telehealth services.

Audiologists provide audiologic and vestibular testing under the Medicare diagnostic benefit category with referral from a physician. Computer-based audiologic diagnostic testing applications are common. Audiologists providing telehealth services use computer peripherals—such as audiometers, auditory brainstem response (ABR), otoacoustic emissions (OAEs), and immittance testing equipment—that can be interfaced to existing telehealth networks. As hearing implant technology evolves, more patients have access to implant devices with synchronous or store-and-forward capabilities. Audiologists use telehealth technologies to provide hearing diagnostic services, including auditory function evaluation for pre-implant candidacy and post-implant status, cochlear implant fitting and programming, pure-tone audiometry, speech-in-noise testing, and video otoscopy. The Centers for Medicare & Medicaid Services (CMS) is reimbursing audiologists for cochlear implant services during the PHE.

SLPs provide evaluation and treatment services under a physician-certified plan of care as part of the Medicare therapy benefit category. SLPs providing telehealth services evaluate and treat a wide range of speech, language, cognitive, voice, and swallowing disorders associated with stroke, traumatic brain injury, neurodevelopmental disorders, neurodegenerative disease, and other medical conditions.

Research demonstrates the efficacy of audiology and speech-language pathology services delivered via telehealth and its equivalent quality as compared to in-person service delivery for a wide range of diagnostic and treatment procedures for adults and children.[1, 2] Studies have shown high levels of patient, clinician, and parent satisfaction supporting telehealth as an effective alternative to the in-person model for delivery of care.[3]

In addition, ASHA's Code of Ethics requires that clinicians use their clinical judgment to determine the most appropriate services for their patients and deliver care via telehealth only if the services are equal in quality to those delivered in person.[4] Delivering care that does not meet the standard for in-person care represents an actionable violation of the ASHA Code of Ethics, which helps ensure patient protection when receiving telehealth services from ASHA certified audiologists and SLPs. A recent ASHA survey of audiologists and SLPs regarding telehealth services during the PHE found that 38% of audiology respondents and 43% of speech-language pathology respondents do not provide services via telehealth because they have determined those services do not meet the clinical needs of individual patients. This demonstrates that ASHA members maintain a commitment to upholding professional ethical standards and are only providing services via telehealth for patients when such services are deemed clinically appropriate and equivalent in quality to in-person care.

Covered Clinicians and Patient Populations

Quite possibly the most important considerations before MedPAC include those surrounding the types of clinicians who should be reimbursed for telehealth services and the patient populations that can receive telehealth services once the PHE ends. These considerations have significant implications for access to services and cost to the program. As noted above, robust evidence exists to support the efficacy of audiology and speech-language pathology services provided via telehealth.

However, MedPAC is considering a limit for telehealth reimbursement to clinicians participating in Advanced Alternative Payment Models (AAPMs) as a mechanism to curb inappropriate utilization and manage the costs to the Medicare program. Unfortunately, this restricts access to audiology and speech-language pathology services. To date, many AAPMs focus on primary care and few AAPMs include services provided by audiologists and SLPs. Many Commissioners

pointed out that telehealth represents a tool of service delivery and restricting its use jeopardizes access to medically necessary, quality health care services. ASHA urges MedPAC to press for policies that allow additional clinicians, including audiologists and SLPs, to use their clinical training and judgment to provide services to their patients in the manner they deem appropriate in partnership with patients and their caregivers.

Medicare has restricted reimbursement for telehealth services in rural areas and only when provided to patients at originating sites. As highlighted by Commissioner Perlin, access issues impact patients regardless of geography. Patients in both rural and urban areas, particularly those with disabilities, can encounter difficulty traveling to an office location to receive services. Dependence on caregivers or limited public transportation options often impede the ability of patients with disabilities to access health care services; an impediment broader access to telehealth could help resolve.

In Section 3703 of the CARES Act (P.L. 116-136), Congress recognized the value of easing outdated restrictions on who may provide and receive telehealth services by authorizing the U.S. Department of Health and Human Services (HHS) to waive limitations under section 1834(m) of the Social Security Act on the types of providers who can furnish such services and on where and how patients may receive them by eliminating geographic and originating site requirements. HHS has used this authority in a deliberate and measured manner; however, the flexibility expires at the end of the COVID-19 PHE. Therefore, numerous bipartisan bills have been introduced in the House and Senate to extend this authority because lawmakers have realized the benefits of telehealth as a service delivery model to ensure Medicare beneficiaries have meaningful access to clinically necessary health care services, both during the pandemic to deter spread of the virus, and beyond to better ensure individuals in rural and/or medically underserved areas have access to needed care. Representatives Mikie Sherrill (D-NJ) and David McKinley (R-WV) recently introduced bipartisan legislation, the Expanded Telehealth Access Act (H.R. 8755), which would expand the list of the providers eligible for Medicare reimbursement for providing care via telehealth to include audiologists and SLPs.

Telehealth can address disparities as well. If barriers to telehealth, such as a lack of access to broadband and technology, are addressed, telehealth has the promise to reduce health disparities across a range of underserved populations because it creates greater access to the health care workforce.[5] Effective and equitable access to health care for vulnerable populations can only be achieved when technological advancements are partnered with appropriate coverage policies.[6]

Therefore, ASHA encourages MedPAC to think broadly about what best helps Medicare beneficiaries maintain access to services that improve their quality of life and their ability to remain independent in their communities. Current restrictions (outside of the PHE) on telehealth services to rural areas delivered to patients at originating sites should be eliminated and all Medicare beneficiaries, regardless of where they live, should have access to telehealth services at a location that optimizes their ability to access these services, whether in an originating site or in their homes.

Reimbursement Rates for Telehealth Services

ASHA does not agree with MedPAC that reimbursement should be lower for telehealth services than for in-person services. Many clinicians will not provide services to patients exclusively via telehealth and will still maintain “brick and mortar” office locations, which include costs such as rent and utilities. Clinicians providing services via telehealth incur practice costs such as the

cost of using a secure, HIPAA compliant platform to engage the patient. Malpractice insurance costs are not reduced or eliminated. In addition, the clinical work associated with delivering these services remains unchanged regardless of whether clinicians provide the service in person or via telehealth. Documentation and claims submission requirements remain essentially unchanged though are somewhat more comprehensive when providing telehealth. As a result, it is inaccurate to assume that the cost of delivering a telehealth service dramatically differs from providing an in-person service. To date, very few payers have implemented payment differentials between in-person and telehealth services.

ASHA recommends MedPAC reconsider its current position that telehealth services should be reimbursed at a lower rate than in-person services. Services should be paid the same rate whether provided via telehealth or in-person. If any payment differential is applied, it should only be applied to the practice expense and made through the established valuation process for all services provided under the Medicare physician fee schedule.

Beneficiary Cost Sharing

ASHA recognizes the importance of reducing or waiving beneficiary cost sharing for telehealth services during the PHE but agrees with the elimination of this waiver at the end of the PHE.

Reinstating HIPAA Requirements at the End of the PHE

Neither clinicians nor patients were prepared for the rapid transition necessary to effectively engage in telehealth care delivery during the PHE. As a result, ASHA agreed with waiving HIPAA requirements during the PHE though we have encouraged our members to use HIPAA-compliant platforms whenever possible. However, once the PHE ends, ASHA agrees with reinstating HIPAA protections.

Establishing Effective Guardrails for the Provision of Telehealth Services

As Commissioner Thompson pointed out, telehealth is a service delivery model, not a distinct health care service. As such, the same protections from monetary fraud and abuse should apply to services provided via telehealth that apply to in-person services. No additional restrictions or guardrails are necessary.

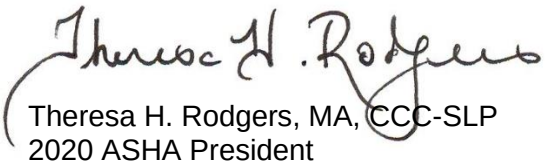
MedPAC has considered whether some forms of restrictions or additional requirements should apply to telehealth services, such as requiring in-person visits periodically over the episode of care (e.g., every 10 visits). Another potential example includes restricting telehealth service delivery to a percentage of the care a patient receives over a given episode (e.g., up to 25% of total care via telehealth). However, this eliminates the ability of the clinician and patient to develop a plan of care reflective of the needs and wishes of the patient. It also undermines the ability of telehealth service delivery as a means to reduce geographic and situational access issues for rural and medically underserved areas as well as the promise telehealth has demonstrated toward reducing health care disparities for racial and ethnic minorities. In a scenario that requires periodic in-person visits over the course of the patient's care (e.g., every 10 visits), the requirement would eliminate access to telehealth for those with mobility problems or geographic isolation that make telehealth access so valuable to certain populations.

Therefore, ASHA recommends MedPAC defer to the clinical evidence and clinical presentation of the patient and not impose arbitrary restrictions or additional requirements, which likely will not improve the quality of care a patient receives. In-person services and those delivered via telehealth must be delivered according to a physician certified plan of care and frequency,

intensity, and duration of services should not vary simply because of the service delivery method chosen by the clinician and their patient. The mode of service delivery should be driven by the medically necessary needs of the patient according to their functional goals and clinical judgement of the clinician and certifying or ordering physician.

Thank you for your consideration of ASHA's recommendations related to Medicare telehealth reimbursement. 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,



Theresa H. Rodgers, MA, CCC-SLP
2020 ASHA President

---

[1] Swanepoel, D. W., & Hall, J. W. (2010*).* A systematic review of telehealth applications in audiology*. Telemedicine and e-Health*, 16(2), 181-200. http://dx.doi.org/10.1089/tmj.2009.0111.
[2] Grogan-Johnson, S., Alvares, R., Rowan, L., & Creaghead, N. (2010). A pilot study comparing the effectiveness of speech language therapy provided by telemedicine with conventional on-site therapy. *Journal of Telemedicine and Telecare*, 16, 134–139.
[3] Ibid.
[4] American Speech-Language-Hearing Association. (2016). Code of Ethics*.* https://www.asha.org/Code-of-Ethics/.
[5] Enlund, S. (2019, May 30). *Increasing access to health care through telehealth*. National Conference of State Legislatures. https://www.ncsl.org/research/health/increasing-access-to-health-care-through-telehealth.aspx.
[6] McElroy, J. A., Day, T. M., & Becevic, M. (2020). The influence of telehealth for better health across communities*.* *Preventing Chronic Disease*, 17(64). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7380287/.