ASHA
American
Speech-Language-Hearing
Association

Submitted via email: Rural_Urban@mail.house.gov

November 26, 2019

The Honorable Danny Davis
The Honorable Terri Sewell
The Honorable Brad Wenstrup
The Honorable Jodey Arrington
The Committee on Ways & Means Rural and Underserved Communities Health Task Force
Congress of the United States
Washington, DC 20515

Dear Co-Chairs Davis, Sewell, Wenstrup, and Arrington:

On behalf of the American Speech-Language-Hearing Association, I would like to thank you for the opportunity to provide a response to the recent request for information on advancing commonsense legislation to improve health care outcomes within underserved communities in the 116th Congress.

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. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists (SLPs) identify, assess, and treat speech and language problems, including swallowing disorders.

ASHA's vision is to make effective communication accessible and achievable for all and ASHA members are dedicated to ensuring that patients in rural and underserved communities can access audiology and speech-language pathology services in the same way as other Americans. Unfortunately, barriers block access to the services and supports necessary for Medicare beneficiaries to communicate effectively—especially those who live in rural and/or medically underserved areas—which adversely impacts their health and quality of life as well as increases their health care costs. In order to serve rural and underserved areas, a more diverse audiology and speech-language pathology workforce is needed. ASHA appreciates that some of the solutions to these policy barriers have advanced in the U.S. House of Representatives this Congress and looks forward to working with this Task Force, the full Ways & Means Committee, and other members of Congress to ensure enactment of these policies. Please find below ASHA's responses to key questions within the RFI, which highlight the bipartisan solutions to the removal of these policy barriers.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Telehealth has shown a demonstrable, positive impact on health outcomes within rural and underserved areas.[1] In particular, telehealth can enhance services for children with hearing loss in rural and medically underserved areas.[2] Research also indicates the efficacy of delivering speech-language pathology services to patients with certain conditions.[3, 4]

Currently, audiologists and SLPs are unable to provide telehealth services under Medicare. However, many states, private insurers, and Medicaid programs have authorized audiologists and SLPs to perform services via telehealth. In fact, last year the Kansas Medicaid program issued a bulletin related to audiology and speech-language pathology telehealth services.[5]

ASHA supports enabling audiologists and SLPs to provide telehealth services to Medicare beneficiaries. ASHA has endorsed the CONNECT for Health Act of 2019 (H.R. 4932) and the Medicare Telehealth Parity Act of 2017 (115th Congress).

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

Last year, the Kansas Medicaid program recognized the importance of telehealth services for patients with communication disorders. The Kansas Medicaid program reached out to ASHA to help define a telehealth benefit related to the services our members provide in order to increase access to rural and underserved communities in the state. Subsequently, the agency issued a new bulletin related to audiology and speech-language pathology telehealth services.[6] One challenge that persists is that while Medicaid beneficiaries in the state can now access audiology and speech-language pathology services via telehealth, Medicare beneficiaries cannot. ASHA recommends that Medicare law and policies be updated to allow audiologists and SLPs to bill Medicare for telehealth services.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The Increasing Nursing Workforce Diversity program has shown demonstratable, positive impact on addressing workforce shortages in rural and underserved areas and populations. The model is successful because it has increased the participation and retention of diverse students, including those from underserved communities, in programs that train and educate nurses.

Currently, 8.2% of ASHA members are members of a racial minority (compared with 27.6% of the U.S. population); 5.3% identify their ethnicity as Hispanic or Latino (compared with 16.3% of the U.S. population); and only 6% indicate that they meet ASHA's definition of a bilingual service provider.[7]

ASHA supports the Allied Health Workforce Diversity Act of 2019 (H.R. 3637), which is modeled after the Increasing Nursing Workforce Diversity program to address the disparities noted. H.R. 3637 would authorize grants to accredited academic programs to increase the participation and retention of diverse students, including those from underserved communities, in programs that train and educate audiology, speech-language pathology, physical therapy, and occupational therapy professionals. A more diverse workforce and workforce pipeline, including individuals from underrepresented backgrounds and underserved communities, is important because:

- minority groups disproportionately live in areas with provider shortages;
- patients who receive care from members of their own racial and ethnic background tend to have better outcomes; and

- members of racial and ethnic minority groups are more likely to practice in shortage areas.

ASHA is pleased that H.R. 3637 has been incorporated in H.R. 2781 as Section 5 and applauds the House of Representatives for passing H.R. 2781 last month.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

ASHA agrees that these providers can be limited in rural and underserved areas but would note that hearing health care providers are particularly limited in these areas. States have taken the approach of allowing for audiologists to practice at the top of their license and allowing for direct access to audiology services. By allowing audiologists to provide both diagnostic and treatment services under the states' scope of practice and providing citizens with direct access to audiologists, delivery of care can be easy to access, especially for those in rural and underserved areas.

Unfortunately, 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. This 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.

ASHA supports the Medicare Audiologist Access and Services Act (H.R. 4056/S. 2446), which would modernize Medicare by enhancing access to hearing health care for Medicare beneficiaries. This bipartisan bill would provide Medicare coverage of both diagnostic and treatment services provided by audiologists and allow for direct access to audiology services by removing language requiring a physician referral, without expanding the scope of Medicare-covered services. ASHA endorsed the Medicare Hearing Act (H.R. 4618), which recently passed the Ways & Means Committee and looks forward to full House passage soon.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

The two policy areas that would help strengthen care quality for rural and underserved populations with communication disorders are changes to the Medicare program to allow audiologists and SLPs to provide treatment to beneficiaries via telehealth and allowing beneficiaries to have direct access to audiologists. Legislation, such as the CONNECT for Health Act of 2019 (H.R. 4932), and the Medicare Telehealth Parity Act of 2017, which ASHA supported during the 115th Congress, would address telehealth barriers. Legislation such as the Medicare Audiologist Access and Services Act (H.R. 4056) and the Medicare Hearing Act (H.R. 4618) would address the access to hearing health care issues.

Finally, the programmatic effort needed to increase care quality for individuals with communications disorders in rural and underserved areas is a new grant program to enhance the diversity of audiologists and SLPs in the workforce. Legislation such as the Allied Health

Workforce Diversity Act (H.R. 3637) and the EMPOWER Act (which includes text from H.R. 3637) would address the quality of care for patients in rural and underserved areas.

Conclusion

Thank you for the opportunity to provide comments to the request for information on ways to advance commonsense legislation to improve health care outcomes within underserved communities. If you or your staff have any questions, please contact Jerry White, ASHA's director of federal affairs, health care, at jwhite@asha.org.

Sincerely,

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

---

[1] C. Cusack, E. Pan, J. Hook, A Vincent., D. Kaelber, B. Middleton (2008). The value proposition in the widespread use of telehealth. *Journal of Telemedicine and Telecare.* https://doi.org/10.1258/jtt.2007.007043.

[2] See Constantinescu, G (2012). *Satisfaction with telemedicine for teaching listening and spoken language to children with hearing loss. Journal of Telemedicine and Telecare.* https://doi.org/10.1258/jtt.2012.111208.

[3] Theodoros, Deborah G.; Hill, Anne J.; and Russell, Trevor G. (2016). Clinical and Quality of Life Outcomes of Speech Treatment for Parkinson's Disease Delivered to the Home Via Telerehabilitation: A Noninferiority Randomized Controlled Trial. *American Journal 214 of Speech-Language Pathology.* [Vol. 25. P. 214-232].

[4] Ward, Elizabeth C. (2015). *Dysphagia management via telepractice: What's the evidence and where to from here?* Retrieved from https://dysphagiacafe.com/2015/12/09/dysphagia-management-via-telepractice-whats-the-evidence-and-where-to-from-here/.

[5] Sunflower Health Plan. (2018). *KMAP BULLETIN: Speech-Language and Audiology Services via Telemedicine.* Retrieved from https://www.sunflowerhealthplan.com/newsroom/kmap-18265.html.

[6] Ibid

[7] American Speech-Language-Hearing Association. (2019). *ASHA summary membership and affiliation counts, year-end 2018*. Retrieved from www.asha.org.