



ASHA

American
Speech-Language-Hearing
Association

Submitted via email: ec.feedback@mail.house.gov

September 26, 2022

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy & Commerce
2202 Rayburn House Office Building
Washington, DC 20515

RE: Request for Information: Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion

Dear Ranking Member McMorris Rodgers:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on select questions to the Request for Information: Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 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 audiology treatment, including hearing aids and cochlear implants. Speech-language pathologists identify, diagnose, assess, and provide treatment for speech, language, voice, cognitive, feeding, and swallowing impairments.

Federal Efforts to Support Access to Assistive Technology

2.1 A. Should Congress consider authorizing Medicaid to reimburse for the cost of technologies that may have secondary uses that are not necessary or assistive, even if the primary usage is for assistive technology purposes? If so, what, if any, limitations should Congress consider when authorizing such flexibilities? Please provide any data on the cost effectiveness of such technologies.

ASHA recommends authorizing Medicaid to reimburse for the cost of technologies only when deemed clinically appropriate by qualified speech-language pathologists (SLPs), including when those technologies have secondary uses not considered assistive in nature. SLPs should be the only clinicians making a recommendation for communication devices, as per their scope of practice, to protect consumers and to prevent fraud and inappropriate use of such technologies. SLPs are uniquely qualified to evaluate and make recommendations for speech generating devices (SGDs) as part of an augmentative and alternative communication (AAC) assessment per their scope and standards of practice, education, training, and transcending competency.

AAC is an area of clinical practice that supplements or compensates for impairment of speech or language production or comprehension, including spoken and written modes of communication.¹ AAC falls under the broader umbrella of assistive technology, or the use of any equipment, tool, or strategy to improve or prevent decline in functional daily living in individuals

with disabilities or limitations. AAC is not synonymous with an SGD, nor does it require that someone be unable to write or speak. Rather, AAC is utilized when communication needs cannot be met without support. AAC systems are an integrated group of components that may be used unaided or aided, which allows an individual to effectively communicate and meaningfully participate in daily activities. Some forms of AAC, like gestures and sign language, do not require an external tool. Other AAC require an external tool like communication books, pictures, and SGDs. AAC systems and interventions are equally clinically effective for both children and adults.² Considerations of communication intervention include multiple forms and modes based on a person's communication needs and preferences. SLPs utilize a wide variety of AAC supports to help individuals participate in daily activities and assist in meeting their communication goals.

Interventions for communication disorders treated by SLPs often include multiple forms of AAC that may have secondary uses not considered assistive. For example, up to 40% of individuals with aphasia—an impairment that results from brain injury—have chronic, severe language impairment and may not recover sufficient language capability to become functional communicators without compensatory support from a variety of AAC strategies. These AAC include drawing, books, remnants, gestures, and writing, as well as SGDs.³ School-aged children similarly have a wide range of AAC needs. A national survey of special educators across all 50 states reported that 18.2% of their students use a form of AAC for their communication mode, which includes 6.9% who use gestural modes, 6.5% who employ picture-based supports, and 4.8% who use an SGD.⁴

Overly restrictive utilization management criteria, and blanket exclusions of technology with secondary functions, present a barrier to accessing clinically appropriate AAC in a timely manner. As Congress considers legislation that would make critical reforms to prior authorization processes in Medicare Advantage, policymakers should similarly be mindful of maintaining access to care in Medicaid. There has been a documented rise in the use of arbitrary and onerous utilization management practices by Medicaid managed care organizations.⁵ ASHA supports efforts to ensure patients have access to all clinically appropriate care, including adequate coverage for AAC.

The goal of an AAC assessment is to determine the optimal system components that will aid communication for the user. In making clinical practice evidence based, SLPs recognize the needs, abilities, values, preferences, and interests of individuals and families to whom they provide clinical services and integrate those factors along with current research and their clinical expertise in making clinical decisions. AAC intervention goals are considered relative to the effectiveness of communication in the form and mode most appropriate for each individual by enabling them to participate more fully in daily communication.

Determining the best communication system is not the end of the process for a patient. For example, individuals with Amyotrophic Lateral Sclerosis (ALS) require AAC and use systems that are multi-modal and change over time. Early in the disease process, an individual may use natural speech with unaided AAC (e.g., gestures, pantomime) and low-tech aids (e.g., a white board). As motor speech deteriorates, the patient may require an SGD such as a tablet with a speech application. Ensuring the patient's ability to communicate using all appropriate options, including devices with secondary uses, helps keep patients out of more costly acute care settings. SGD users may also need services to support customizing, accessing, and using technology to reduce the risk of abandonment of the device. AAC interventions and services need to be tailored and customized to each individual and may require support, including caregiver training, to be successful.

Fewer than 5% of individuals with complex communication needs are employed full-time due to, at least in part, a lack of effective and efficient communication and lack of functional literacy skills.⁶ For example, only limited numbers of individuals with autism spectrum disorder secure work after school, and these positions typically involve part-time, low wage jobs. Furthermore, many of these individuals are unable to maintain these jobs—employment rates drop significantly for each year post-high school.⁷

ASHA encourages the Committee to develop Medicaid policy that gives patients robust access to all clinically appropriate treatments utilizing AAC recommended by qualified SLPs. With appropriate access to AAC technologies and interventions, Medicaid beneficiaries with complex communication needs can improve their functional communication, enhance language and literacy skills, increase educational achievement, secure successful employment, decrease challenging behaviors, manage health care needs, and more actively participate in their communities. Adequate coverage of AAC and support services is critical to the success of our students, the health of our patients across the lifespan, and the economic opportunity for people with disabilities. AAC can help those who use it to perform job tasks that they may otherwise not be able to perform and help people with disabilities transition and adapt to different workplace settings and needs.⁸

Federal Efforts to Support Accessible Health Care

2.2 D. How have telehealth and other remote monitoring technologies been used to improve accessibility to health care services for people with disabilities? How did the utilization of such services during the pandemic improve access to care or mitigate a worsening of access to care? What should Congress consider when examining future extensions of telehealth and remote monitoring authorizations?

ASHA agrees with the Committee's assessment that, "telehealth was a silver lining during the pandemic", and that its use during the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) increased access to necessary audiology and speech-language pathology services, particularly for Medicare beneficiaries, the homebound, and individuals with disabilities.⁹ Upon reviewing data on telehealth usage—which included 1) an independent analysis of 2020 claims data, 2) data reported by ASHA members associated with cost, outcomes, and satisfaction, and 3) audiology and speech-language pathology registry data—ASHA has determined that telehealth coverage is a critical method of health care delivery both inside and outside of a pandemic, and congressional action is needed to ensure continued access to care.¹⁰

In 2020, the Centers for Medicare & Medicaid Services (CMS) used authority granted under Section 3703 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) to allow audiologists and SLPs to be reimbursed for select telehealth services during the COVID-19 PHE. After using this authority to cover a limited number of audiology and speech-language pathology services in 2020, CMS added 24 additional codes for audiology and speech-language pathology to the list of authorized Medicare telehealth services for use during the PHE. This expansion of available reimbursable codes reflects continued support for telehealth delivery of these services. As a result, beneficiaries have enjoyed more comprehensive access to telehealth services provided by audiologists and SLPs, including diagnosis and treatment for a wide range of hearing, balance, speech, language, swallowing, and cognitive disorders.

Patient satisfaction surveys and claims data from both CMS and private health plans demonstrate that many Americans view telehealth as a positive improvement to our health care system. Most voters believe Congress should protect their ability and choice to see a provider via telehealth beyond the PHE.¹¹ In its March 2021 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that 90% of Medicare beneficiaries reported being “somewhat” or “very satisfied” with telehealth services.¹² Telehealth services are shown to increase continuity of care, extend access to care, help overcome provider shortages, and reduce patient travel burden, among other benefits.¹³ Despite initial concerns that increased access to telehealth services might lead to increased fraud and abuse, a recent report by the Office of the Inspector General (OIG) for the Department of Health and Human Services shows these concerns might have been unwarranted. In the report, the OIG noted that 0.2% of claims were at “high risk” of being fraudulent.¹⁴ ASHA asserts that this is an indication that providers are evaluating the appropriateness of furnishing services through telehealth and supports expanding current telehealth authorities and flexibility in the future.

Earlier this year, Congress enacted the Consolidated Appropriations Act of 2022 (Public Law 117-103) which included a provision to enable audiologists and SLPs to continue furnishing services via telehealth for 151 days after the COVID-19 PHE expires. ASHA supports congressional action to ensure Medicare beneficiaries have continued access to necessary hearing, balance, speech, language, swallowing, and cognitive care provided through telehealth permanently.

The delivery of audiology and speech-language pathology services through telehealth has and will continue to improve access to health care for people with disabilities. For example, a report commissioned by ASHA examining telehealth utilization for audiology and speech-language pathology services during the pandemic found that services delivered via telehealth through Medicaid accounted for approximately 3% and 9%, respectively.¹⁵ ASHA maintains that the delivery of services through telehealth under Medicaid and in Medicare fee-for-service was an important way for vulnerable populations to maintain access to speech-language pathology services. These included services critical to reducing barriers to community and work, and to improving quality of life, such as hearing assessments, treatment of speech and language disorders, and evaluation for AAC devices, such as SGDs.

The utilization of services through telehealth during the pandemic also has improved access to care for vulnerable populations, including Medicare beneficiaries and individuals with disabilities. Many seniors and those with disabilities who lacked transportation and/or whose conditions made them more susceptible to serious adverse outcomes from COVID-19 availed themselves of services via telehealth that they otherwise would not have received, or that would not have been obtained in a timely manner. ASHA’s National Outcomes Measurement System (NOMS) is a voluntary data collection registry that incorporates data reflecting patient-reported outcomes, billing practices, diagnoses, and clinical outcomes for audiology and speech-language pathology services that illustrates their value and enables clinicians to improve the quality of those services. Data collected through NOMS demonstrated that the majority of clinicians who documented services provided through telehealth 1) reduced costs to patients, 2) decreased missed appointments, 3) prevented adverse outcomes, and 4) improved patient compliance.¹⁶ These benefits contribute to improved quality of life, participation in work and the community, and lower systemic health care costs. The trends associated with satisfaction and outcomes of care were comparable to services provided in person.

During the pandemic, private health plans also dramatically expanded their telehealth coverage. Several large national plans, such as UnitedHealthcare and Cigna, have established permanent

policies covering audiology and speech-language pathology services provided via telehealth. These improvements in telehealth coverage indicate a notable change in the understanding of the effectiveness and efficiency of telehealth services. Medicare beneficiaries deserve access to telehealth services comparable to individuals covered under private insurance.

When examining future extensions of telehealth authority, ASHA maintains that it is critical to ensure that services provided through telehealth are reimbursed at the same level as services provided in person. The costs of delivering telepractice services require providers to make investments in infrastructure and devote time and resources to preparation that are not required for services delivered in person. Data collected through ASHA's NOMS registry indicated that clinicians invested an additional average of \$2,373 in overhead over the past 12 months for equipment such as tablets, computers, and secure software to deliver telehealth services. Respondents also reported an average of an additional 107 minutes needed to prepare for delivering telepractice services, such as ensuring patient familiarity with equipment usage.¹⁷

ASHA also maintains that telehealth services should only be provided when the clinician believes in their appropriateness and equivalence to in-person care, in part to provide safeguards against waste, fraud, and abuse, and overutilization. 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.¹⁸ 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.

An ASHA member survey on telehealth services during the PHE found that 38% of audiology respondents and 43% of speech-language pathology respondents do not provide services via telehealth when they have determined those services are not clinically appropriate for individual patients. This demonstrates that ASHA members maintain a commitment to upholding professional ethical standards and only providing telehealth for clinically appropriate patients when audiology and speech-language pathology services are equivalent in quality to in-person care.

ASHA has endorsed H.R. 2168, the Expanded Telehealth Access Act, sponsored by Representatives Mikie Sherrill and David McKinley, which would expand the list of providers eligible for Medicare reimbursement for telehealth services to permanently include audiologists and SLPs. This bipartisan legislation would give Medicare beneficiaries more options to access critical hearing, balance, speech, language, swallowing, and cognitive care.

ASHA also supports a longer-term extension of telehealth waivers that exist during the COVID-19 PHE as an interim step toward permanent telehealth authority, and has endorsed H.R. 4040, the Advancing Telehealth Beyond COVID-19 Act of 2022, which the House passed in July. Section 3 of this bill would enable audiologists and SLPs to continue furnishing services through telehealth through 2024. ASHA remains committed to ensuring Medicare beneficiaries are granted permanent access to audiology and speech-language pathology services provided either in person or via telehealth based on the patient's needs and preferences and the clinician's professional judgment.

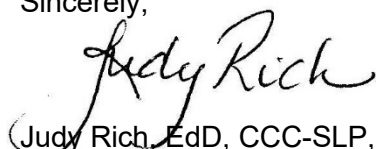
Conclusion

ASHA agrees with the Committee that accommodations in health care settings, such as the ability to receive telehealth services and coverage of assistive technology, can have profoundly positive impacts on patient outcomes and satisfaction. As such, the continued ability of

audiologists and SLPs to provide services through telehealth under Medicare, and Medicaid coverage of AAC devices and systems when clinically indicated, will help achieve your goal of “helping those in need by making the United States freer and more accessible to all Americans and ensure that our safety net is functioning for those who need it most.”¹⁹

Thank you for your consideration of ASHA's recommendations. If you or your staff have questions, please contact Josh Krantz, ASHA's director of federal affairs, health care, at jkrantz@asha.org.

Sincerely,



Judy Rich, EdD, CCC-SLP, BCS-CL
2022 ASHA President

¹ The American Speech-Language-Hearing Association. (n.d.). *Augmentative and Alternative Communication (AAC)*. <https://www.asha.org/public/speech/disorders/aac/>.

² The American Speech-Language-Hearing Association. (n.d.). *Introduction to AAC*. <https://www.asha.org/nic/aac/>.

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⁴ National survey describing and quantifying students with communication needs. (2017). <https://www.tandfonline.com/doi/full/10.1080/17518423.2017.1339133?scroll=top&needAccess=true>.

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⁶ Light, Janice & McNaughton, David. (2014). Communicative Competence for Individuals who require Augmentative and Alternative Communication: A New Definition for a New Era of Communication? *Augmentative and Alternative Communication*. 30. 1-18. 10.3109/07434618.2014.885080. https://www.researchgate.net/publication/261547401_Communicative_Competence_for_Individuals_who_require_Augmentative_and_Alternative_Communication_A_New_Definition_for_a_New_Era_of_Communication.

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⁸ <https://choosework.ssa.gov/blog/2017-08-21-using-assistive-technology-in-the-workplace>.

⁹ Committee on Energy and Commerce. (2022) “*Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion*.” p. 24.

¹⁰ The American Speech-Language-Hearing Association. (n.d.). *NOMS*. <https://www.asha.org/noms/>.

¹¹ Telehealth Access for America. (n.d.). Poll: Voters Overwhelmingly Support Urgent Action to Permanently Protect Access to Telehealth. <https://telehealthaccessforamerica.org/poll-voters-overwhelmingly-support-urgent-action-to-permanently-protect-access-to-telehealth/>.

¹² Medicare Payment Advisory Commission. Telehealth in Medicare after the coronavirus public health emergency. https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch14_sec.pdf.

¹³ Department of Health and Human Services (2021). Telehealth for Providers: What You Need to Know. <https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf>.

¹⁴ Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks. U.S. Department of Health and Human Services Office of the Inspector General. September 2022. <https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf>.

¹⁵ Average Cost and Utilization for Audiology, Occupational Therapy, and Speech-Language Pathology Services. (2022). https://www.milliman.com/-/media/milliman/pdfs/2022-articles/8-9-22_average-cost-and-utilization-for-audiology.ashx.

¹⁶ American Speech-Language-Hearing Association. (n.d.). National Outcomes Measurement System. <https://www.asha.org/noms/>.

¹⁷ The American-Speech-Language-Hearing Association. (2022).

<https://leader.pubs.asha.org/doi/10.1044/leader.PA.27072022.telehealth-data.16/full/>.

¹⁸ American Speech-Language-Hearing Association. (2016). Code of Ethics. <https://www.asha.org/Code-of-Ethics/>.

¹⁹ Committee on Energy and Commerce. (2022) “Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion.": p. 28.