

MEDICAID AND THIRD PARTY PAYMENT IN THE STATE OF INDIANA

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Relevant events, affecting the profession, occurred in Indiana during the winter of 1971; these events should prove to be a learning experience for us. The story really began at the 1971 Summer ARA meeting in Winter Park, Colorado. Harford reviewed the efforts of the Hearing Aid Industry Council and hearing aid dealers to sell Congress and federal agencies on the notion that they, alone, could handle all the needs of the hearing impaired. According to these sources, in most cases, the services of audiologists would not be needed. Furthermore, the hearing aid dealer was now calling himself a hearing aid specialist, a more prestigious sounding title, presumably strengthening the case for total case management in the absence of the audiologist.

Beulter leveled some scathing criticism at this same meeting and his words contained wisdom for those who listened. He noted the lack of any truly wide-based recognition by the public or lawmakers of the health service provided by audiology, as well as the importance of the related issue of legal identity provided by licensing. We were reminded that hearing aid dealers were identified by law in over half the states of the nation while audiologists could say the same for fewer than five states. Almost prophetically, he emphasized the issue of the impact of federal health legislation on the very nature and future existence of our profession.

The rude awakening in Indiana occurred under the banner headline, "WE ARE FIRST." It was in the October 1971 issue of the *National Hearing Aid Journal* that we learned that "... for the first time anywhere, hearing aid dealers... are recognized as providers under a government Medicaid Program, just as are physicians, dentists, optometrists, and various other practitioners." The guidelines for this program were developed by The Indiana Hearing Aid Association, The Department of Public Welfare, Blue Shield, and The Indiana Academy of Ophthalmology and Otolaryngology and provided "... for the registered hearing aid specialist-dealer to proceed, after medical clearance, with the testing, evaluation, selection, fitting and follow-up services related to fitting hearing aid instrumentation..."

A committee of hearing aid dealers was established to review each case before the fiscal agent would provide reimbursement. The committee had the authority to call for the services of an audiologist if it deemed it necessary. It should be noted that in one year of operation, under the guidelines when more than 500 aids were reimbursed, the services of an audiologist were not utilized in a single case. This is of importance because, although the guidelines contained extensive audiologi-

cal information, the audiologist was mentioned only once. On the other hand, the guidelines said almost nothing about hearing aids and little about hearing aid dealers. The warnings of Harford and Beulter had come home to roost and our greatest fears were realized.

We were surprised to learn that one major impetus for these guidelines came from a fairly substantial hearing aid fraud case which the Medicaid people felt they could not handle with existing procedures. You see, hearing aids had been reimbursed under this program for almost two years. Medicaid had a problem but we felt that their solution was inappropriate. The state and fiscal representatives to the program were receptive to the case that we presented and accepted new guidelines which we felt would better serve the hearing impaired public. The hearing aid dealers had been there first and, regardless of problems with the end result, much work had gone into the guidelines development. In fairness to the State Department of Public Welfare, as well as Blue Shield, it should be mentioned that somehow, hearing aid dealer assistance was more accessible to them than audiology input. Let us review the old guidelines before discussing the new ones.

Under *General Information*, on the first page of the guidelines, is the earlier mentioned single reference to an audiologist as a possible consultation source. This minor role (actual participation never even reached this minor level) is particularly ironic when you realize that, on the same page, the dealer is told that the prescribed audiometric hearing test form must be used for all hearing aid fittings. The only advice about the selection of a hearing aid, however, is that the dealer shall consider motivation, mental condition, general physical condition, ability to manipulate controls, and previous hearing aid experience. Solicitation of Medicaid patients is prohibited in this section. This point is important in view of the fact that the earlier mentioned fraud concerned solicitation of elderly persons in nursing homes.

The next section concerns *Procedures for Testing, Fitting, and Dispensing of a Hearing Aid*. There are a number of details in this section, some of more interest than others. The dealer is instructed to do pure tone testing including "air," "bone," and "masking" in both ears. He is also instructed to obtain results of speech threshold and discrimination tests in addition to various other measurements. Perhaps the best summary of this section of the guidelines is contained in the remarks of a hearing aid dealer with whom I spoke. When we discussed the matter, he remarked, "Yeah, I saw that David. I bought a \$1600-portable audiometer and I am reading Newby like hell."

In the next section is listed the statement that ambient noise levels in the test environment should not cause a shift in the threshold of a normal ear, a vague statement at best. Fairly routine matters follow including a statement that a dealer must have an established place of business with office hours posted on the door.

Equipment standards indicate that the audiometer shall meet the "ANSI or ISO 1964 standards." Indication of an understanding of the difference between these two standards or the role of the earphone is

completely lacking. The next item states that speech audiometers must meet ANSI specifications, "the output of which shall provide earphone levels of 100 dB re .002 dynes/cm²." Although the guidelines cite "... .002 dynes/cm²," in this section they use the term "... .0002 dynes/cm²," elsewhere. There is no telling where this problem with reference level terminology originates, but I like to think that if an audiologist had been involved in the development of these audiometric forms and procedures, such confusions would have been avoided.

Under the above mentioned statements on reference level are five categories, the first of which is entitled, "Ear Inspection." The hearing aid dealer is charged with responsibility for advising the client "... to see a physician, preferably an ear physician," based upon his otoscopic examination. It should be noted that, under these guidelines, the patient may be examined by any practitioner licensed to practice medicine in the State of Indiana. This situation puts the hearing aid dealer in the peculiar position of making critical decisions based upon otoscopic examination. This is a responsibility which is not commensurate with his training, experience, or legal status. During a committee meeting in which these matters were discussed, a participating otolaryngologist of some stature in the state was, to say the least, perplexed when a dealer tried to assure him of his competency to handle otoscopic examinations by citing the mail order courses he took to increase his skill in this area. This little incident rather succinctly exemplifies the issues raised by these guidelines and the question of the responsibilities of various groups concerned with hearing health care in the State of Indiana and probably in the nation.

If we continue a detailed examination of the guidelines, there are a number of other points that we can include. There is a curious use of cps rather than Hz and db instead of dB indicating that the writers of the guidelines were in unfamiliar territory in handling this terminology. The dealer is instructed when to mask by the following brief statement: "Masking should be employed when there is a 30 db difference or greater in any of the above frequencies, between the average level of loss in both ears." There is also a rather detailed statement on how to conduct the necessary medical examination. This point is noteworthy because it places the hearing aid dealer in the unusual position of instructing the physician in what is necessary for his medical examination.

The hearing aid dealer's legal status in Indiana will now be discussed. Hearing aid dealer legislation emerged because of unscrupulous practices on the part of some members of its group. In response to growing complaints about these activities, dealers became registered under Indiana law in 1967. The introduction to the statute makes its purpose quite clear.

"An ACT concerning hearing aid dealers and providing for the regulation of certain business activities in connection therewith and prescribing penalties."

A hearing aid dealer is defined as "...any person who fits or dispenses hearing aids and who receives a commission or salary derived from the sale of such devices." But, in the same paragraph, and by way of exclusion, it separately defines a clinical audiologist according to the familiar ASHA standards.

The dealer must take an examination to be registered but that examination may "...not be conducted in such a manner that college training be required in order to pass..." This statement was included in the law in recognition of his background and training. Further indication of the intent of the legislation is contained in the Prohibited Trade Practices section which prohibits

"Using the words "doctor," "clinic," "clinical audiologist," "state licensed clinic," "state registered," "state certified," "state approved," or any other term, abbreviation, costume or symbol when it would falsely give the impression that one is being treated medically or professionally, or that the registrant's service has been recommended by the state."

Following implementation of this legislation, there was a substantial reduction in the more obvious and blatant types of unscrupulous behavior. In short, the "fly-by-nights" were forced out of the state. The more subtle forms of dishonest behavior were not so well controlled, however, even though equal in magnitude and seriousness. Witness the fact that allegations of a major fraud did not receive recourse through use of the hearing aid legislation. It should be remembered that this legislation contains provision for fines and loss of registration which would negate the right to sell hearing aids. New guidelines, however, with broader powers for hearing aid dealers were developed.

After careful but rapid study of the guidelines and consultation with the Executive Council of the Indiana Speech and Hearing Association (ISHA), it was decided that the Audiology Committee of ISHA should assume responsibility for negotiations to change these guidelines. Support and authority were given immediately and wholeheartedly. Our colleagues in ISHA, many of whom had little to do with audiology, and even less with hearing aids, immediately viewed this situation in terms of its impact upon the profession as a whole and responded accordingly. The president of ISHA, although not an audiologist, was always available to us and responded to all of our requests. I am convinced that this total support contributed largely to our success.

Two points became immediately obvious to us as we initiated our campaign. The first was the lack of awareness of the "who," "what," and "where" of audiology. Although third party personnel had heard of audiology, they did not really know who we were. They were unacquainted with what we did and remarkably uninformed as to where we worked. The second point related to the first and explicitly pointed out by the parties with whom we were negotiating, was that we were not licensed in Indiana. In fact, our first task was to prove our right to challenge the guidelines by documenting our legal right to provide

health services under Medicaid. Although we had existed for about thirty years, we were not yet legally defined. Fortunately, ASHA had been doing its job and audiology, as well as speech pathology, had been defined in the parent national Medicaid Act. We got past that hurdle but never for a moment forgot the urgency of being legally defined, i. e. licensed.

Colleagues in other state departments concerned with speech and hearing services, medicine, and other health related professions were appraised of the situation and were of great assistance. They supported our position and indicated the need for our incorporation into the Medicaid program. Our consumers, i. e., hearing handicapped persons, parents of hearing impaired children, or their groups, supported our efforts through letters and personal contacts with Medicaid officials.

Our negotiations were not without difficulties, misunderstandings and frustrations. Attempts to have the old guidelines temporarily withheld pending discussions of new guidelines proved futile. Medicaid felt that a great deal of effort went into the old guidelines, and that they needed to be kept operational if only in an act of faith to the hearing aid dealers who had worked on them. We reached some stand-by agreements as to the role, authority, and responsibility of audiology during the negotiating period when the old guidelines were still in effect. Nevertheless, we received copies of hearing aid dealer communications instructing their colleagues in procedures which were in direct opposition to those agreed upon. There were other stresses and strains too numerous to cite and, in this stage of reminiscence, perhaps better left to drift into the background. The only point to remember is that these were serious and difficult times that demanded the utmost attention, effort and coordination of all segments of our profession.

A noteworthy part of our discussions concerned the role of audiology in selection and rehabilitation efforts relative to hearing aid dispensing. Once the principle of inclusion of the audiologist in the program was accepted, it was argued that our only responsibility should be audiometric assessment. Selection of an aid and other related matters could only be decided by the dealer. We were successful in arguing against this position by educating Medicaid officials about the historic clinical and research efforts of the professional audiologist in this area, and by pointing out the various components of the educational process of the audiologist which prepares him for this activity. It was also pointed out that Medicaid would in effect be legislating the audiologist out of an activity he had historically conducted if it prohibited him from selecting the hearing aid or engaging in other post-fitting activities. On the other hand, it was made clear that the audiologist would be free to modify procedures according to his professional judgement regarding his patient so that he might elect to make as general or specific a hearing aid recommendation as was necessary for the client.

The final phase of our efforts involved numerous meetings with hearing aid dealers, otologists and Medicaid representatives resulting in essentially tough negotiations. As a result of these meetings a new set

of guidelines finally emerged. We felt that these provided for a quality service easily available to all segments of the hearing impaired public. They contained a reasonable division of authority between the various groups involved in the delivery of services and products.

The new guidelines were structured around three components: medicine, audiology, and hearing aids. The procedures were outlined as follows: No hearing aid will be reimbursed without the patient receiving a medical examination, preferably by an otolaryngologist. All children under 15 years of age must receive their examination from an otolaryngologist. Upon completion of the medical clearance examination, an audiological evaluation must be conducted. This must be performed by an audiologist or an otolaryngologist. The audiologist must possess the CCC-A or be in the Clinical Fellowship Year. The audiological evaluation shall have three components: the determination of 1) need for additional medical examination, 2) suitability of amplification and selection of a hearing aid, and 3) functional benefit from use of a hearing aid. The functional benefit criterion is satisfied by having the patient return for an evaluation after he has received his hearing aid. Only after the post-delivery evaluation indicates satisfactory benefit from the aid does the audiologist sign the audiological form required for reimbursing the hearing aid dealer.

The third stage is the delivery of the hearing aid. The kind of hearing aid referral used is determined by the audiological examiner. It can range from a specific referral by hearing aid serial number to a general referral status that a hearing aid is indicated. The audiologist can make the decision about the kind of hearing aid referral based on local conditions including consideration of the expertise of the cooperating hearing aid dealers.

Under this plan, the hearing impaired person is afforded the best treatment through the cooperating services of the physician, audiologist, and hearing aid dealer. Although considerable time, effort and negotiation went into these guidelines, the hearing impaired public will benefit from them.

There are a number of conclusions which we consider to be critical lessons both for ourselves and our colleagues around the country. They are listed below, not necessarily in order of importance:

1. Beulter's comments go to the heart of the matter. If we believe that our profession offers a real and vital service to the hearing impaired, then we will have to tell the world about it, fight to see that our services are deliverable, and see to it that we continue to exist as a professional entity so that we may continue to provide these services.
2. Legal definition through state licensing of our profession is essential to guarantee public access to our services. (Legislation to license speech pathologists and audiologists in Indiana was passed in April, 1973. We took this lesson especially seriously.)
3. Expansion of the perogatives and/or authority of hearing aid dealers through guidelines or administrative fiat is unfair

to the hearing impaired as well as the dealer himself. Our original Medicaid guidelines ascribed tasks to the dealer that sent him scurrying to Sunday seminars and mail order courses to learn material routinely taught in university programs. This is grossly unfair to the dealer as well as the public. State department personnel, physicians and other groups were not fully cognizant of this part of the story but were very receptive once they received the facts.

4. The success of our effort was, in no small way, due to the fact that we represented ISHA. We fought a bit between ourselves, but each of us modified our position somewhat in order to present a unified and coherent force behind the official position taken by the association. We also tried to make sure that all segments of the association knew what was happening. This made it possible to ask for their support at critical moments.

5. Closely allied to this last point were our efforts to develop lines of communication with other health professionals. When they understood our position, they tended to support us. Furthermore, we were able to avoid conflict with positions which they have taken.

6. The Medicaid incident was a terrible shock. We had been complacent but these guidelines resulted in our action. Ironically, we have those who are responsible for the guidelines to thank for a new awareness. Not only do we have new guidelines (and licensure), but ISHA now has a very active audiology committee which works very hard to insure the continuation of quality professional services to the public. It monitors activities not only in the capital but all over the state in an attempt to anticipate difficulties before they occur. Committee members also make themselves available for consultation and information to state personnel having questions concerning audiological services.

7. My review of activities throughout the country indicate that our situation in Indiana is not unique. Reports tell of dealers fighting to call themselves audiologists in some states. In others, attempts are being made by hearing aid dealers to transform their operations into "professional speech and hearing centers." In addition, reports reach me of hearing aid dealers attempting to negotiate contracts for the delivery of a total speech and hearing service for public school districts.

8. To some groups, the field of audiology must seem like an underdeveloped market with rich potential, a sort of a "ripe plum" waiting to be picked. Our role and activities were of small interest to them when there was little money available to pay for the needs of the speech and hearing impaired. That has changed with the advent of state and federal programs. Third party payments are the substance which I believe ripened

us in the eyes of many and made us seem ready for picking. We must recognize the changing circumstances surrounding the delivery of speech and hearing services. We must take advantage of new opportunities to provide better services to the handicapped who we serve, and, at the same time, move beyond the charity model for the delivery of services. We must also strive to do that which will insure our continued existence as a profession able to deliver these services.