Thank you for the opportunity to respond to the request for information regarding the hearing care market. My response will focus on three related topics: Cost of care, Quality of care, and Access to care.

Patient satisfaction has never been higher in the U.S. hearing care market. MarkeTrak9 data shows 81% overall satisfaction compared to 74% in 2008 and 95% of hearing aid owners are satisfied with the professionals that fit them with the amplification. This has led to higher adoption rates which currently are estimated at 30.2% compared to 24.8% in 2008 (MarkeTrak9, 2015).

Many of these facts were cited at the recent FTC hearings and, yet, the discussion seemed to attribute these improved patient outcomes strictly or, at least primarily, to improved technology. While technological advancements certainly have contributed to increased adoption and satisfaction, little attention was paid to the enhancements in professional education of audiologists and their role in these success factors.

In 2008 the accreditation standards for Audiology education changed to require graduates to earn the Doctor of Audiology (Au.D.) clinical professional degree. This was a transition from the existing master's degree to the new Doctor of Audiology. The new standards resulted in more didactic coursework and clinical experiences including a one year residency/externship. This compared to the older master's degree model of 1-2 years of academic training with limited clinical experience under the direction or supervision of the academic program. So, while there certainly have been advancements in technology, there also has been associated enhancements in audiology education. This has resulted in audiologists who are more cognizant of the co-morbidities associated with hearing loss and the relationships between hearing loss and cognitive and cortical reorganization necessitating extensive rehabilitation associated with the fitting of hearing aid devices. Yes, there have been advancements in technology, but the advancements in audiology education and the role that audiologists play in the successful fitting and utilization of these products, through audiology rehabilitation programs, have been the primary reason for improvements in patient outcomes.

As noted during the recent FTC hearings, in markets where there is no formal audiology education, such as Japan (JapanTrak 2015), outcomes and patient satisfaction are quite poor despite the adoption of the same hearing aid technology provided to hearing aid consumers in the U.S. Similarly, in a study of AARP members on the "State of Hearing Health" AARP members were asked "which would be critically important to you if you were seeking help for a hearing difficulty?" Respondents said "finding a provider with a high level of training on hearing difficulties" was of greatest importance (AARP, 2011). Also, in a survey "Exploring the Consumers Journey" of successful hearing aid consumers, Taylor and Rogin (2011) found that the number one factor in hearing aid success was the relationship with the provider and the consumer's ability to continually connect with the provider. While factors such as cost and technology were mentioned, they were rated well below the benefits derived from the relationship, management, and treatment received from the audiologist (Taylor and Rogin, 2011).

Of course, patient success comes at a price. As noted during the FTC hearings and those of PCAST and NAS, the final consumer costs of hearing aids are comprised of the cost of the product plus the

professional services necessary to successfully fit the product and manage and treat the patient. The product is viewed by audiologists as a part of management and treatment and not THE management and treatment. That is a key difference when discussing the elimination of professional services with OTC products. Costs may be reduced with the elimination of audiology services, but patient outcomes may be seriously compromised. There is a reason that patient outcomes and satisfaction have dramatically improved in recent years and to suggest that it is all about the product would be a serious misunderstanding of what is involved in the management and treatment of individuals with hearing loss. Doctors of Audiology are integral to successful outcomes.

While legislation, standards, license laws, and definitions may be changed for the products, there seems to be little discussion about changing the delivery system which Scott Davis in his FTC presentation accounts for as much as two-thirds of the final costs associated with a successful hearing aid fitting and treatment program. As noted by Stephanie Czuhajewski and Dr. Ian Windmill on the FTC panels, throughout the past decade or more, representatives from professional associations have had extensive meetings with CMS and have introduced federal legislation to help consumers manage the costs associated with hearing care. Unfortunately, this has all been to no avail and there have been no changes in access or out of pocket costs for Medicare beneficiaries.

Freeman and Lichtman (2005) using CMS data provided in the year 2000, demonstrated that CMS could have saved $168m in the year 2000 by permitting Medicare beneficiaries, with a complaint of hearing loss that was not medically or surgically treatable, direct access to an audiologist. Today, that savings would be significantly higher. Also, consider that Medicare only pays 80% of the covered services so that beneficiaries would have paid out of pocket $33.6m (20%) of the costs paid to physicians to make the necessary referral to an audiologist for their evaluation in the year 2000.

CMS is among the only third party still requiring a physician referral for an audiologic evaluation and CMS still restricts audiologists from providing covered rehabilitative services that are within their legal and professional scopes of practice and required for patient management. While the Federal Employee Health Benefit Plans (FEHBP), the Department of Veterans Affairs (VA), and Medicare Advantage Plans administrated privately permit audiology management and treatment without physician referral, traditional Medicare beneficiaries must pay out of pocket for these services. If a change should be made that positively affects cost and access to care, then <u>CMS should be required to permit beneficiaries direct access for audiology services and should cover the rehabilitative services associated with audiology care.</u>

Please note, this is **<u>not</u>** <u>a request to cover the cost of a product</u>. Instead, it is a request to cover the rehabilitative management and treatment services that may be associated with the successful fitting of a product and that are so critical to patient outcomes. In that manner, consumers can select their product independent of a professional (e.g., OTC) but the diagnostic, management, and treatment services provided by an audiologist that are necessary for successful patient outcomes would be covered and would not require physician oversight or a referral.

Since there is a desire to make a difference in the cost and accessibility for hearing care, then there also should be an equal effort to address the factors that truly impact these factors without compromising the quality of patient care and assuring successful patient outcomes.

Thank you for the opportunity to discuss this very important topic and I hope my comments provide some new and valuable insights into this issue.

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