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Labyrinthine Reimbursement for Hearing Aids:
Navigating the Puzzle
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- [Christy] At this time, it's my pleasure to introduce our presenters. The main presenter today is Dr. Robert Fifer who is currently the director of audiology and speech-language pathology at the Mailman Center for Child Development, Department of Pediatrics University of Miami School of Medicine. Dr. Fifer's clinical and research interests focus on the areas of auditory evoked potentials, central auditory processing, early detection of hearing loss in children and auditory anatomy and physiology. But before we hand it over to Dr. Fifer, we would like to welcome Dr. Powers, who would like to give a short introduction. Welcome, Dr. Powers, and at this time, I'll hand the mic over to you.

- [Dr. Powers] Thank you very much, Christy. I just wanted to take a couple minutes to provide another short welcome. For those of you that may have already seen it, this webinar is sort of in conjunction with Seminars in Hearing. Seminars in Hearing just completed an addition on MarkeTrak 10 in which we had several grade articles covering a whole scope of issues from the reimbursement that you'll hear about now. Owners, non-owners, some things related to the OTC and direct to consumer aspects, as well as just some of the overall MarkeTrak 10 issues. And of course, in that issue, Dr. Fifer was one of the contributors and I was very pleased that he agreed to do that for us in regards to the MarkeTrak 10. I've been doing some consulting with our industry since my semi-retirement from Sabantos. I was asked by Catherine Palmer to be the guest editor for that addition, and again, I was very fortunate to have a number of great authors. I've known Bob for quite some time, as well as his family, his parents who were very active in hearing aid business for a number of years and sort of feel like a part, somewhat part of the family. You're going to get some great information in regards to this topic of reimbursement from Bob today. And again, it's certainly my pleasure to introduce both a colleague and a friend, Dr. Bob Fifer.

- [Dr. Fifer] Thank you, I'm glad to be here. And indeed, you have been part of the family for a long time. My parents opened the doors to their hearing aid company in 1955, and without exaggeration, I grew up in it. And so, I'm seeing a lot of these things

I'm gon' be talking about firsthand. More recently, I have not been as involved with the hearing aid from the corporate perspective, as I was early on, but from the reimbursement perspective, I've been hip-deep in that for quite a while now. My disclosures, I'm employed by the University of Miami with regard to other sources of income, couple of honorarium and I have no non-financial disclosures to report.

Learning outcomes to identify benefits and constraints of insurance HMO reimbursement for hearing aids and related services. To execute appropriate procedures to discover coverage policies established by Medicaid agencies, insurers and HMOs. Identify the most appropriate charge and reimbursement model for each respective practice in addition to the impact of imposed charge and reimbursement models. And this last bullet is probably gonna be most important for you all as I lay a lot of foundation and build up to that point later on in the presentation because a one-size-fits-all simply does not exist. It's going to be up to each of you to determine what model of dispensing and reimbursement and gainful employment is going to be most appropriate for you as determined by your professional setting, your geographical setting and your past experience. We start off by looking back at the good old days. The commercialization of hearing aids began in the 1950s.

I'm going to go through a brief discussion of the history of all of this because that lays the foundation of where we are today with regard to charging and reimbursement models for hearing aid practices. In that day and time, there was really no such thing as audiologist dealing with hearing aids. Individuals went through a factory training to become hearing aid dealers as they were called at that time. There were franchises, which in essence, were exclusive distribution contracts available from a number of companies, which meant that you were the only company in that area to offer that brand of hearing aids. Hearing aid selection was based primarily on pure tone testing. We were very basic back then in terms of the armamentarium for what eventually would become audiology and the purchases were very straightforward, they were either cash or contract. And in the case of a contract, quite commonly, the bank would by the contract and take a percent off the top and then reimburse the hearing aid

dealer, the office for the remainder of the cost of the contract and that way the cash flow would be virtually instantaneous. And the other point is at the fixed overhead, because of that arrangement, typically was very low compared to today. The bundle price model was a matter of necessity in its beginnings. There was no separate reimbursement for hearing testing because diagnostic hearing testing was available in the military primarily for people coming back from war time exposure. Hearing conservation really had not taken off yet. And so, the realization was that you needed to do a hearing test in order to know what kind of hearing aid or the adjustments on the hearing aid would be most appropriate for the individual. Hearing aid pricing was typically set as a beginning mark point based upon the manufacturer's suggested retail price. There was no consideration of professional services versus equipment cost, no breakdown comparable to what we would experience today. The price could be negotiated, hence the term dealer, as opposed to a hearing instrument specialist, which is a preferred term for a non-audiologist dispenser today. There can be some negotiation for the price but the calculation of the cost of service was not even a consideration.

Today, it's the total opposite because you got to know today how much it costs you to deliver services. If you don't know that, you run the risk of going out of business really fast if you're just trying to base your prices based upon what John Rasselfrats down the street is trying to do. And other than a receptionist, perhaps, if even that, there really was no need for office staff because there was no insurance payment involved, that did not come in until a number of years later. And so, the fixed overhead was very, very low and the bundle pricing was obvious, it was necessary because there were no other options and it was very well established early on. The technology of the 50s was the transition out of vacuum tubes. If you looked at pictures of hearing aids way back when, it was a big old box that hung on your chest with batteries strapped to the legs sometimes. Technology was beginning to advance and the key players were Raytheon, also known today for other things starting with Radar, and Bell Laboratories, the early telephone giant. Earlier brands were Siemens, and in the research for this article, I

learned that Siemens has been around as a corporation since 1913. It's been around a long, long time. Acousticon was a famous brand back then that no longer exists. Maico and Belltone were the other two brands that have survived through the ages. Oh, I'm trying to push my keyboard for the next slide, that doesn't work. Here we go. In the 1960s, Zenith Radio Corporation went into the hearing aid business, and they realized that there was a problem with these new transistors. The hearing aids didn't last real long, the transistors, as in their early development, were very heat sensitive, and we're talking body heat sensitive. And so, the person would buy the hearing aid, use it a few weeks, and then by virtue of the impact of body heat on the transistors, the hearing aid would die. And so, Zenith came up with a better transistor in the 1960s and in doing so, became king of the hill, so to speak, among the more prominent brands of hearing aid. Belltone was right up there with them and as a durable brand, but Zenith appeared to be superior in part because of its vast experience in building radios.

Also in the early 1960s, the space program provided direct input to the hearing aid industry with electronics that were more reliable and also smaller, reducing the size of the hearing aid. A lot of the fitting that took place at that time, and this is an important point to carry forward, a lot of the fitting consisted of guidance counseling on maximizing use of the hearing aid. Hearing aid dealers would sit down and listen to the individual and help walk them through many times based upon the day-to-day experience. And I want you to put a pin in that for just a second because we're gonna come back to that very shortly. The frequency and the maximum output were adjusted by potentiometers on the back of the hearing aid with a little screwdriver. And I remember, all that technology persisted into the early '70s when I was in audiology training. And I remember many times adjusting the frequency response for the MPO based upon turning the screw driver rather than reprogramming a hearing aid. In 1967, there was a publication that came forth in Asha Magazine, criticizing the hearing aid dispensing community, the practice of dispensing hearing aids at that time. This was done by audiologists associated with Asha, and basically what they were saying was that this is very unscientific, it needs to be done in a better way. That's Fifer's very

loose paraphrase of the article itself that came out in 1967. But it set up a clash between the audiology community and the hearing aid community on the basis that audiologists wanted to rely on more, quote, scientific, unquote, methodologies of prescribing hearing aids. Whereas a hearing aid dealer at that time looked at the audiogram and when choosing a hearing aid, that was in the ballpark basically on the curve of the audiogram and then would make final adjustments with the potentiometers. But with a lot of counseling, a lot of guidance and a lot of conversation with the individual, and the two communities were far apart in their practice on that. And literally in the late 1960s, there was all-out war between the audiologists and the hearing aid dealer community. I got caught up in that indirectly quite innocently when I applied for graduate school admission to a particular university. I was rejected, not because I wasn't qualified, but because I was the son of a hearing aid dealer, and at that time, that phrase was used in a such a way that it was not a compliment. That's how strong the animosity was between the two communities.

The point being is that all of these things were forces opposing each other and had a direct impact upon the reimbursement schedule, the reimbursement methodology that carried through for a number of years. In 1965, another seminal event was a passage of the modification Social Security Act to establish Medicare and Medicaid, Medicare provided benefits primarily for the elderly. And as an aside, I just got an email notification that our grocery stores here in Florida are now having special hours for the elderly because of the coronavirus, and I looked at their age range and that now includes me, I did not realize I was elderly. But from 65, up was the focus of the benefit for Medicare, Medicaid was designed for the poor and that's in quotes. Today's Medicaid is also designed for the medically complex or medically needy, not necessarily the poor but someone in need of a variety of services that financially went bankrupt in the family otherwise. Now, from the very beginning, audiology was placed in a benefit category called other diagnostics only. And this meant that we were to perform diagnostic evaluations of hearing and we were not recognized for any rehabilitation functions, which really was a basis of establishing the profession of

audiology coming out of World War II. Northwestern University was mecca where as far as auditory rehabilitation was concerned, and also considered by many to be one of the very early homes of the origin of audiology as a profession. But in the late 1960s, audiology was also struggling for its identity and it wanted to identify itself in terms of clinical and diagnostic capabilities, university teaching. The auditory rehabilitation was still coming through and carrying through from its beginnings following World War II and also audiological research. Now, when we talk about diagnostics only, you have to picture in your mind what our armamentarium was at that time. It was pure tone air, pure tone bone, speech reception thresholds, speech discrimination, tone decay, the alternate loudness balance test, ABLB, and the monaural loudness balance, MLB, and the SISI test.

If I had survey capabilities here, I would wonder how many of you have even heard of the SISI test, the short increment sensitivity index. We were training as tumor trackers basically at that time and that's how we wanted to establish ourselves as a profession. The most common places of employment for audiologists in the late 1960s, going into the '70s was in a physician's office, usually an ENT or in community speech and hearing centers. The events of the 1970s and 1980s, the AMA began the CPT coding process about the same time that Medicare was signed into law. But even as late as 1970, the number of CPT codes could be typed on two pages, single spaced with a lot of room left over, and oh, by the way, there was no CPT manual. The copies were mimeographed and then mailed to those who wanted to abide by this coding system. In the early 1970s, the other seminal event was that audiologist began dispensing hearing aids. And Asha was really up in arms about that, calling them rogue audiologists and such things as that, just because the whole concept of hearing aid dealers was frowned upon by this group that was central to Asha at that time. And so, rogue audiologist who were dispensing hearing aids became synonymous with the reputation placed upon hearing aid dealers at that time. And remember now the war was still ongoing between the audiology community and the hearing aid dealer community in the early '70s. But when audiologist began dispensing hearing aids, their

primary competitor was John Rasselfrats down the street, hearing aid dealer, who was charging a single price that included the hearing test, the instrument and all of the aftercare. And so, to be in competition, that is what and how audiologist began to price their services as well. Now Medicare would reimburse audiology for hearing testing, and I'll go into that in the next slide in just a second, but that was a minor part of what was going on in the health care community overall at that time. Technology-wise, hybrid hearing aids started coming out in the mid-to-late 1970s and this was essentially a digital controller overseeing the function of analog amplifiers and then the fully digital hearing aids began their first appearance in the early 1980s. Hearing aid selection, preceding dispensing was based primarily on what was called the Carhart Technology. And the Carhart Technology, or Carhart Method, rather, would lay out two or three different hearing aids, usually different manufacturers, slightly different specifications and you would put it on the individual with a temporary ear tip simulating an ear mold, and you would present to them a monosyllabic word list or something comparable. Later on, it was a synthetic sentence word list at times in some clinics. And you would look to see which one gave you four, six, eight, 10% better performance on the monosyllabic word list, and also, by the way, how did that hearing aid sound to you? And that was basically the dispensing methodology at that time based upon the technology that was available. Medicare, as I said, did pay the price on the diagnostic test to audiologist, the problem mostly for the audiologists who were working in a physician's office, the payment went to the physician via what's called incident to billing. Under that arrangement, audiology was invisible to the process, the physician billed Medicare on behalf of the audiologist and the payment went to the physician, not the audiologist. Private practice audiologists were typically not billing Medicare to a great extents, a great ascent.

- [Dr. Powers] Yes, talk, Bob.

- [Dr. Fifer] Had to push my upper dentures back up, getting old these days, they say, just ask our grocery store. The audiologist, by and large, were not billing Medicare,

perse, the ones in private practice. That didn't come in for quite a while later. But yeah, there was to be a payment for audiological services delivered by an audiologist, it was to be a qualified audiologist, someone with a graduate degree and someone with certification. The other payment condition was medical necessity and this condition holds true through today. Medical necessity is that the hearing loss itself was not previously diagnosed or if it was diagnosed, there is a change in status for the presentation of the new symptoms. The testing also could not be for the sole purpose of purchasing a hearing aid, since by federal law, when the Medicare program was established, Medicare was forbidden to purchase hearing aids. And there are a number of reasons behind that, one was the cost of it, another was the technology, another one was the perspective that hearing aids were optional in terms of providing any benefit to the individual. The way this happened, audiologist would do the hearing aid evaluation, write a prescription and then send the individual down to a trusted hearing aid dealer. And trust is in quotes because the trusted hearing aid dealer was someone who would not change the recommendation rendered by the audiologist without clearing it with the audiologist first.

So that's where things were in 1974, '75, '76. And then Medicaid, which is a combination federal-state program, also established in 1965, began to grow and look at different things, hearing aid, hearing coverage was part of it. And this was influenced in part by the Veteran's Administration and the Department of Defense, it was also influenced in part as an optional benefit. Remember hearing aids, at that time, and to some degrees yet today, are considered optional with regard to adult benefit, adult use of hearing aids. Back then, the technology was such that it was believed that hearing aids didn't necessarily provide all that great a benefit because a person still said, huh, huh, what? And so, that simply reinforced the optionality of hearing aid benefit. Today, adult hearing aids are still considered an optional benefit category that is not mandated by Medicaid. There's a number of states who do provide hearing aid benefits to adults but there's no uniformity from one state to another, with regard to the eligible hearing loss level. Some states have a pure tone average a 40 decibels as being eligible to

walk through the door for a hearing aid. Some states require 25 and some 35 and it's all over the place. The only thing common about all the Medicaid programs is that there is nothing common about all the Medicaid programs. Coverage pricing also varied greatly with regard to the cost reimbursement for the hearing aid, as well as a dispensing fee. The replacement period in some states is three years, in other states, it's two years, in other states, it's four years. Again, no uniformity there. And the follow-up requirement for payments generally does not exist in adult Medicaid programs, such as what's known as the conformity visits to make sure that the hearing aid's working well, the person's working well with the hearing aid. No further costs are necessary, or I'm sorry, no further adjustments are necessary to the programming these days of the hearing aid itself. Medicaid coverage of hearing aids for children was present virtually from the beginning.

The major difference between adult qualification and child qualification is known as EPSDT, early and periodic screening diagnosis and treatment, EPSDT. Fundamentally what EPSDT says that if you find a problem that can impact a child's development, you must, not you can, you must respond to that problem by doing whatever is necessary to help that child overcome that problem that can alter development in any way whatsoever. And so, coverage of hearing aids and therapies were mandated for children through the Medicaid program, payment was based upon legislative allocations from both child and adult and not any particular formula. It was basically the whim of what the state legislature wanted to reimburse. Sometimes it was based upon data, many times, it was based upon how low can you go in getting the manufacturers to come down on the wholesale price? And often, the device and accessory payment was simply a pass through. Whenever the manufacturer charged you for the price of a hearing aid, Medicaid would reimburse that price. And in a number of states, that's still how it works, Florida is one of them. Other states do increase the price of reimbursement, but it's still nowhere near what you would get on the open market, nor is it sufficient, generally to cover the cost of service delivered. And because there is no reimbursement between child and adult for diagnostic or

hearing aid services, this tends to limit access to hearing services for Medicaid eligible individuals or children. Children mandated coverage under Medicaid, so if you are a Medicaid provider, you are required to offer your services to children. But with no difference in the reimbursement level between child and adult, a child takes longer, a child is more labor intensive and time is money. I know you've heard that in many different ways, in many different context situations, but time is money. And because of that, Medicaid hearing services for children tends to be a money loser. And so, in many places in the country, access to hearing services for children and for adults in the states that offer it can be very limited, simply because the reimbursement is so low, people think it's really not worth the effort. Now this is something, a statistic to be aware of. Medicaid in each state occupies a significant portion of each state's general revenue fund. I'm using Florida's dollar amount as an example here. The other states will vary somewhat in percentage and also quantity. Florida just passed a 93 billion dollar budget for the entire state. Medicaid costs occupy between 25 and 30% of the state budget. And oh, by the way, 52% of the births in Florida are covered by Medicaid.

Now conservative legislative bodies have worked to cost shift the risk of the Medicaid provision of healthcare services in general, including hearing services to private HMO firms. And in turn, private HMO firms have looked to utilization management review companies to subcontract with who are designed mainly to control the flow of patient access to services with that HMO, and also designed indirectly to inhibit access to services for that HMO. Even though we're talking about Medicaid here, I want you to be aware of this point because the non-Medicaid HMO services, many times, will use the same utilization management review companies in order to control patient flow and to inhibit patient flow to that HMO's services, including hearing services. The management review company is responsible to the HMO, the HMO is responsible to the Medicaid agency. And so, there's that in between layer of the HMO structure, the hierarchy between the Medicaid agency for the state and the subcontractor. That's good for the subcontractor, it's not good for those of us who are providers. And

outside the Medicaid region, the Medicaid coverage area, that similar arrangement exists, obviously you don't a Medicaid agency overseeing this but the utilization management review company is responsible to the HMO and must control costs more than HMO. They're designed to, depending upon the nature of one utilization review or multiple utilization review companies, they're intended to cover all services or apply it to all services offered by the HMO. Now, coming back to Medicaid, I'm gonna close it out, I think with this slide. The utilization management review entity must abide by regular Medicaid guidelines with regard to eligibility. They cannot be capricious and arbitrary and saying you qualify, you don't. Whatever the Medicaid guidance for that state is, they are required to follow those rules, but they are not required to maintain Medicaid reimbursement prices. They are free to adjust the prices on their own, higher or lower than the state Medicaid guidelines will offer. They can be a single network that covers the entire state for all of the HMOs contract into that state or they can be contracted to a specific single HMO that varies a lot from state to state, and they can add to the Medicaid eligibility rules as long as it doesn't restrict access to services.

One of the rules mean you've gotta have medical clearance, you gotta have a physician sign off on it one step beyond the normal involvement of the primary care physician for Medicaid that we often find as requirement, both for Medicare and Medicaid. And then, once again, they're trying to limit the access based upon the reimbursement model at hand. Okay, hang on to that, because we're gonna see it in a little different perspective in just a moment. The access to hearing services has been quite an attention-getter in recent years because of the complaints put forward by such organizations as AARP, for example, and other consumer based organizations. There is a public perception that the cost of hearing aids is exorbitant and it's inhibiting access to hearing services all throughout the country. This perception has been influenced by a number of different things, including the bundled pricing that got its start back in the 1950s and then carried through to when audiologist joined the group, in terms of dispensing hearing aids. Whether or not insurance will cover the hearing aid cost and the associated out-of-pocket expenses, we'll take a look at that in a moment. Peer

comments on the utility of hearing aids. "I've got one of those things, didn't do me any good, "just took in the dresser drawer." And comments like that, we hear that and sometimes we kinda smile depending upon how it's presented. But comments like that can really pierce through a community like a lightning rod and that can really turn people off to the benefit and utility of hearing aids. Governmental reviews on hearing services, on hearing aids. The criticism on the expense of hearing aids, there are two committees that we'll talk about momentarily that looked at that. The pricing models, the bundled price, and the perception that the entire price of a hearing aid, even though part of it may be reimbursed or is eligible for reimbursement or by Medicare for the diagnostic portion. The entire price on the hearing aid is for the instrument itself, not considering the professional services. And then also physician comments about the need for physician involvement because hearing loss is a medical problem that typically, historically has been the purview of otolaryngology, and also primary care to some extent too. That they need to look after this individual and make sure the individual is being treated well. There are legislative mandates for insurance coverage of hearing aids in approximately 23 states.

Last count from the lit review I did did specify 23 exactly. Whereby an insurer or an HMO is required to cover hearing aids. Now the laws vary a lot from one state to another, and don't necessarily specify to what degree the insurance coverage will cover the hearing aid. Also has a range of variability, in terms of the maximum eligibility age. A lot of these were originally targeted for children and then extended to adults in some places. Georgia, for example, has a maximum age of 18 years, Delaware, 24 years and some other states, through adulthood. The replacement period varies between three years and four years. And then the amount of coverage can vary from \$1,000 to \$3,000. Sometimes it's per hearing aid. Sometimes it is the accumulative coverage of two hearing aids, 1000 to \$3000, it depends on the contract with that insurer or the HMO. And in states without a legislative mandate, you find insurance coverage and HMO coverage of hearing aids less often. And if you should see it, it's not necessarily the same level of coverage, even for the same company as what it

would be in a state that has a mandated coverage for hearing aids. The out-of-pocket costs is something that has been a strong influencer, in terms of the perception of accessibility and I wanna walk you through this just very quickly. The average price... Let's see, yeah, there's my pointer. The average price of a hearing aid is about \$2100 and some change, this is an average price. Later on, I'll show you a slide where the low is in the 500 to \$1,000 range, high is well over \$3,000 per unit. Now, if the individual had third-party assistance, then those who had insurance, their average price was somewhat less. My glasses are failing me. Yeah, about the same as the, in the first block up here. Those without insurance had a little bit difference in average price, but still the same neighborhood. Now, I want you to skip down to this right here. The out-of-pocket expense was, on average, more than \$1,200 per hearing aid unit. The third-party coverage for that hearing aid, on average, remember now, there's a lot of variability here, on average, was \$800, about \$870. So the out-of-pocket cost was substantially more than what the insurance would cover for the hearing aid. And yes, you had insurance coverage, but there was still a lot left over that had to be paid by the individual.

Now this graph shows third-party sources of assistance. I'm not gonna say covering, I'm gonna say assistance at this point in the cost of hearing aids. What's on my screen has more of a yellow line, a gold line, if you please, takes into account all hearing aid users in the sample. The blue line takes into account only the hearing aid owners who had third-party assistance in paying for the hearing aids. One of the things I want you to pay attention to here is the role of the military and the VA, in terms of providing assistance. It was much more common regardless of which denominator you use, all hearing aid owners in the survey or just those with third-party assistance, it was much more common for the military and the VA to provide assistance to the individual than anyone else. The next thing I want you to pay attention to is the Medicare Advantage. Medicare Advantage is a Medicare Part C program that basically requires the same eligibility as Medicare for services but has the freedom to add additional benefits. And so, Medicare Advantage, not universally, not all Medicare Advantage offers hearing aid

coverage but Medicare Advantage can offer hearing aid coverage or at least part of the cost of hearing aids, and you can see that it's the second in line after the military and VA. The third is HMO. And the HMOs and the commercial HMOs can have some contractors through whom they dispense hearing aids, and that is the third most common among them all. And then the fourth would be Medicaid. And after Medicaid, you have a family member or a friend, union contracts, charitable organizations and all others. So the type and availability of third-party assistance that you see here varies a lot, but there is some third-party assistance out there. But the main thing I want you to remember is that with the exception of the military and the VA, and some Medicare Advantage Programs, some, some, I want to emphasize some, that there is still an expense to the individual on payment out-of-pocket expense.

Now models of hearing aid and dispensing, the contracted provider network can come in two forms, I have variation one listed here. Each audiologist is contracted with the corporation serving as a provider network, and these networks will assemble audiologist under their corporate heading. The audiologist and support staff are actually employees of that provider network and they approach an HMO by saying we are a turnkey operation. We will monitor your expenses for hearing related services, hearing aid and dispensing and we will take care of it for you. They contract with the healthcare company, the HMO typically, and they receive a capitation rate, which is a fixed dollar amount per subscriber, per month, to cover all the services necessary for the subscribers enrolled in that HMO. In addition for this model, the audiologists are encouraged to provide services to individuals who are not related to that HMO contracted in any way, shape or form. So, and their core focus will be the HMO, but they are free and actually highly encouraged, if you please, to provide services to people not affiliated with that HMO. The second variation of a contracted provider network is the audiology practice remains independent of the network provider. So you have a corporate entity who's contracting with your private practice and you become a contracted part of that corporate entity, but you're not absorbed by it, you're still independent, when your contract expires you can go your own way. And through that

contract, you receive referrals linked to the contract that network has with a specific HMO. So the HMO has a subscriber, the network corporate entity receives the information about that subscriber and that network corporate entity refers to your practice. So it's a three step operation basically. Now be aware that under this model, the brand selection, the pricing and the reimbursement to your practice can be fixed and limited in some cases depending upon the network and your contract with that network. There may also be practice restrictions on the evaluation and how the evaluations are performed. So you have to be fully cognizant of what you're getting yourself into with this provider network, with the first one, you're an employee of that network. And so, as an employee, you have a better idea from day one, not always 100% idea, but a better idea. This one, you've gotta enter the situation with eyes open. I'm not saying it's a bad thing, I'm saying you need to be aware of what it is, what it means to your practice and what financial impact it can have on your practice. Now, there's a hybrid model as well, a hybrid contracted network where this model and the audiologist or the practice contracts with a national firm or administrative resources and hearing aid purchasing options.

Now the potential advantage here is that the national firm will provide assistance with marketing, financial monitoring for your practice, human resources to keep you legal in the labor market and billing and coding as well as business development. A lot of audiologists do not take business courses, there may be a business course in your AUD program, but a business course in the AUD program doesn't cut it for what you need to know in the business community, and so, having access to these services can be a tremendous benefit to you. Now, it does require a membership subscription, but in attempts to save money by reducing your fixed overhead costs, because you spread it out over all, the fixed overhead of the administration part is spread out over all of the subscribers. The sales and reimbursement are not linked to, I found a typo here, ensure her really should be insurance. I was using voice recognition software. To insurance or an HMO, in particular, and the proceeds come directly into the practice. A cooperative network is a group that comes together, different practices that remain

independent, but they have a cooperative agreement and each practice has a single vote to elect a board of directors. It's designed to increase the efficiency of each practice, access to marketing, media outlets, administrative support and staff training. They share the overhead expenses with reduced overall costs to each individual practice, again, because it's being spread out among all the subscribers in the co-op. And another advantage is that it has greater negotiating influence for purchasing volume discounts to the hearing aid manufacturers. Minus the profits and sharing expenses, all the profits go into each practice. And then a simple purchasing co-op is when a group comes together and says we're going to establish an order with Oticon, how many hearing aids do you need this month? Or how many do you anticipate needing? They do the same thing several other audiology practices, they submit the order as one large bulk order and then receive a discount based upon that, and that really is the only benefit to the simple co-op is the reduced wholesale cost. There is no central administrative organization and really no benefit beyond that reduced wholesale.

Balanced billing, here is where you got to have a contract, and I mean, physically in your hands, have a contract between your practice and the HMO or the insurer because some insurers and HMOs will allow balance billing, others will not. And so, you've got to know what the rules are so that you don't violate the contract and get kicked out because there can be the risk of some financial penalty, if you get kicked out because you violated the rules of the contract. If insurers and HMOs are really bad about giving you a copy of the contract and you sign the contract and then you send it back to them and they sign it and then the contract disappears into the darkness. If your practice doesn't have a copy of that contract, you need to contact the provider relations specialist within that insurance company or that HMO and have them send you a copy of your contract. Because you've got to know what the rules are that you will abide by because the other thing to be aware of is that there are occasions when the insurer or the contract has it written in the original draft will change the scope of the contract without your knowledge. And so, you've got to have something to fall

back on, you've gotta have a hard copy of that contract to fall back on, so you know what to expect with regard to freedom, these professional services and the reimbursement. Bundling versus unbundling, you can't pick up anything more controversial. As far as hearing aids are concerned, then do you bundle or don't you bundle? All of healthcare is moving toward greater transparency, all of healthcare. And there's nothing special about audiologist in this respect, but access to hearing healthcare has captured the attention of the federal government via AARP, via other consumer groups. Access to our services in general, hearing services and hearing aids has been looked upon recently with a scan to I wanting to know why the cost is so great. And as a fallacy, they have used the cost of hearing aids to the VA as a benchmark. The VA pays on average about \$400 in hearing aid.

Why can't everybody do that? Well, the VA orders several thousand hearing aids at a time and you talk about volume discount? That's a volume discount. It doesn't cost anywhere near \$400 to manufacture a hearing aid, so the factory is still making a profit, and the large order allows the factory to make a very handsome profit all at once. But individual practices or even groups can't do that on the magnitude of the VA but that was the benchmark that was being used. There were two national committees that looked at this about four years ago. The president's council of advisors on science and technology known as PCAST and the National Academies of Sciences, Engineering, and Medicine used to be called the Institute of Medicine, now it's just called the National Academies. And both of 'em came up with basically the same conclusion, that access to hearing Healthcare is limited at least by perception, if not, reality, based upon the price of the hearing aid or the perceived price of the hearing aid. And they're looking at the bundled price of the hearing aid as representing the totality of the instrument itself without due consideration of the professional services to program, select, fit the hearing aid and the aftercare that's required. Now the average price of hearing aids was mentioned earlier is about \$2160. Now the range up here, let me get my little pointer. The range for up here is as low as 500 to 999, and over here, more than 3,000. So there's quite a range and what they were looking at was the total price

per hearing aid. The total price for hearing aid, not the breakout on the professional versus instrument services, the total price. And there is a public perception that this total price represents only the thing that goes over the ear or the tube that goes in the ear. You wanna be aware of that. The pricing model. The great majority of pricing had a single charge for everything, 64%. What we talked about in terms of pricing back in the 1950s, 1960s, still runs very strong today. 64% is the magic number in this survey. Only about 12% broke the pricing out, and when it was broken out, it was primarily for the hearing test and the evaluation, follow-up care when the number of visits exceeded what was authorized in the original contract, sometimes each individual follow-up is charged to the individual like an auditory training session, for example, or AR session, and then there's miscellaneous over here. But the biggest breakout was the cost of the hearing test or the evaluation. This was it, but the vast majority of what's dispensed today is a single price model going back to the 1950s. The influences on unbundling begins with the Medicaid, typically requiring unbundling of the hearing test versus instrument versus the ear mold versus dispensing. In some states, the mandates on refunds by state law take into account the separate charge for the diagnostics and don't require the charge for diagnostics.

Some states will say that you have to refund the cost minus a certain percentage, and theoretically, that takes into account the diagnostics, the professional services that were done. But the greater involvement of insurance is an HMOs has turned in toward unbundling, now it doesn't mandate it, it's not all there, but there is a trend starting to appear toward unbundling through the influence of insurances and HMOs. And then transparency in pricing. One of the things that PCAST and the academy reported was that it wanted more transparency in hearing service pricing. And there are many different formulas for unbundling, one of the things that I want to drive home is that unbundling does not mean that you charge the invoice price on a hearing aid or the invoice price of an ear mold because there is a cost to your practice to order that hearing aid, to receive the hearing aid, to stock that hearing aid until it's finally dispensed. There is a markup that should go along with it to cover the administrative

overhead of that part of that function of the practice. And the potential advantage to unbundling is to make it more transparent, as to how expensive the instrumentation is, relative to the cost of service delivery and the professional services. There are occasions as determined by insurance coverage or geography when unbundling is not appropriate, and this can be specified either in contract or by virtue of circumstances. And establishing price points. If you go out on Google and look up the cost of service delivery, you will come across many different websites that give you formulas on how to do this. I'm not gonna go into that now because of time, I'm running out of time at the moment. But you've got to make sure that you know on a per procedure or per hour basis, how much it costs you to deliver services to ensure that any contract you signed with an HMO, with Indemnity insurance, your pricing of a hearing aid is sufficient to cover the cost of service delivery as you have calculated.

And also your administrative overhead and your fixed overhead for utilities, insurance and so forth as well as any profit margin and cash reserve. You've got to know how much it cost you to deliver services in order to know whether or not to accept Medicaid or to participate in an HMO or insurance program. If you don't know that and simply price your hearing aids based upon what John Rasselfrats charging down the street, then you're likely to run into trouble. I'm gonna summarize this slide and the next slide very quickly out of respect for time. Over-the-counter hearing aids and PSAPs all do offer the opportunity to have a great influence on audiology practice. The influence is to take audiology back to its roots to rehab as a major part of what we do to provide assistance to the person with hearing loss. This slide did not turn out well, but to summarize it, your role in all of this, a hearing care professional, your role in all of, this slide would have said how important was the hearing care professional to you as you purchased your hearing aid? And roughly 80%, I'm sorry, 90% said either very important or this large black area or somewhat important here. So you do play a very important role in all of this in helping them with the hearing aid and adjusting to the hearing aid. It is not something that you can put on their head, pat 'em on the head and say go live a good life. My concluding thoughts is that there are a lot of things that are

very different now than they were 60 plus years ago when hearing aid dispensing really began in its infancy. Our knowledge about what goes on has increased tremendously, in terms of the causes and effects of hearing loss, the capabilities of the hearing aid, the cochlear function and central auditory function and its influence on hearing loss. And also, the financial and business-related influence of insurance and HMO reimbursement, and then the looking to the future, the self purchase Of over the counter hearing aids and also PSAPs. A concluding thought, yes, Virginia, we do live in interesting times! And I think you all very much.

- [Dr. Powers] Thanks, Bob, this is Tom Powers, again, thanks so much. I think this was really great and sort of one of my concluding thoughts is I think I get to go with you to the grocery store at the same time. Unfortunately, because I was also one of those folks when I finished my PhD, it pains me to say, in 1977, and went immediately to private practice. Felt some of the pains that you were talking about in terms of some of the wars and what was going on in that time frame. It was a very different time in terms of dispensing and unbundling back then and now we're talking about it again some 40 plus years later. So, again, thanks so much. And again, thanks to AO for hosting this, thanks to Seminars for also being a part of this and also the Seminars in Hearing edition on MarkeTrak 10 and HIA for actually putting all the data together. So, I don't see any questions in the Q&A, and Christy, if that's the case, oh, wait, I think I do see one up here.

- [Dr. Fifer] Yeah, there's one.

- [Dr. Powers] Great, go ahead. That's for you, Bob, that's not for me.

- [Dr. Fifer] Won't obtain any contracts due to possible changes. Your contract will have an expiration date with it. And before that expiration date comes about, you should begin negotiations with the HMO or the insurer to renew that contract because some of the conditions on the contract may change from year one to year two, and so,

look to see what the expiration date is and then go from there. Another question, we can all take our hearing aid screwdrivers and SISl forms with us to the grocery store. Ooh, I'd like that! Oh, I like that. You just made my whole day worthwhile. And there's another question that popped up there momentarily, it's gone now.

- [Dr. Powers] We'll wait one more minute maybe and see if there's anything pops in, but otherwise, I don't see any and I think Christy, yeah, I think that's that, Christy is saying it's time, we're four minutes over. Thanks, Bob, thanks for everybody participating, thanks to AO. And Christy, if there's anything else, if not, thanks and have a great weekend everybody.

- [Christy] Thank you both, thank you both and I hope that this has been a valuable resource. Have a great day everyone.

- [Dr. Fifer] Y'all take care and be well.

- [Dr. Powers] Yeah, you too, be well, Bob.