Defining Audiology through Occupational and Health Policy Action

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ABSTRACT

Many barriers to accessibility exist for Medicare beneficiaries seeking hearing and balance care such as availability of providers, coverage for services, and ability to pay. Other statutory and administrative barriers exist including the need for physician orders to have audiology services covered, the classification of audiologists as suppliers of "other diagnostic tests" under Medicare payer policy, and noncoverage of certain audiologic management and treatment services. Nearly two decades of legislative efforts have not resulted in any substantial changes to U.S. health policy, while the need for audiology services has increased due to a growing demographic of older adults. The Medicare Audiologist Access and Services Act (MAASA) has been introduced in the 116th and 117th Congress and proposes amendments to the Social Security Act that would address statutory barriers to accessing hearing and balance care among Medicare beneficiaries and would recognize audiologists for their scope of practice within the Medicare program. Objectives of the present review are to provide a summary of statutes in the Social Security Act and Standard Occupational Classification system which affect audiologists, audiology services, and Medicare beneficiaries and to discuss previous and current legislative health policy efforts to address these statutory barriers to hearing and balance care access.

KEYWORDS: audiology, Medicare, health policy, healthcare reform, health insurance

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The profession of audiology originated following World Wars I and II, as large numbers of servicemen and servicewomen returned from battle with hearing loss and other related auditory disorders such as tinnitus.[1] Originally, audiologists primarily specialized in the assessment and nonmedical management of hearing loss and have since expanded their education and expertise to provide audiologic management of hearing and balance disorders. Despite the drastic changes in the education of audiologists and the profession of audiology, definition of audiologists under Medicare policy has changed little for nearly 50 years due to a variety of statutory and legislative barriers. At present, incongruence between practice and policy leaves audiologists in flux and many patients unable to access hearing and balance care due a scarcity of benefits and/or an inability to pay out-of-pocket for such services.[2–4]

The profession of audiology was still taking shape when the Social Security Act (SSA) of 1935 was legislated and enacted. Classification of audiologists was defined post-facto and their respective services were mostly non-covered because they were deemed to be "routine and low in cost."[5] Similarly, the profession of audiology intersected with the creation of the Standard Occupational Classification (SOC) system in 1977, only a decade after the first accredited audiology training programs were established.[6] As a result, audiologists' initial classification by federal standards poorly reflected current practice, which in turn affected classification in federal healthcare regulations and statutes.

As the profession of audiology emerged, there was a need for representation. In 1947, the American Speech Correction Association changed its name to the American Speech and Hearing Association and began representing and supporting the needs of audiology professionals.[7] In 1978, the ASHA changed its name to the current American Speech-Language-Hearing Association (ASHA).[7] In 1977, the Academy of Dispensing Audiologists was founded to promote and champion audiology professionals dispensing hearing aids in rehabilitative practices.[8] At the time when the dispensing of hearing aids for profit was considered unethical by the ASHA, audiologists performed diagnostic testing and then sent patients with hearing loss to hearing instrument dealers to purchase hearing aids. On April 25, 1978, the U.S. Supreme Court upheld a lower court ruling in the case of the *National Society of Professional Engineers versus the United States*.[9] The ruling stated that pursuant to the Sherman Act, the society could not require its members to adhere to a code of professional ethics that disallowed competitive bidding on projects.[9] Indirectly, this ruling forced the ASHA to lift its ban on "for profit" hearing aid dispensing for the members of its association.[1]

By the mid-1980s, audiologists began to express dissatisfaction with audiology representation by the ASHA, an organization largely composed of speech-language pathologists. A small group of six audiology leaders met at the 1987 ASHA convention to discuss the formation of a national association that would provide a professional home for audiologists.[1] On January 30, 1988, the American Academy of Audiology (AAA) was established to focus its efforts solely on professional issues and concerns impacting audiologists in all settings.[10]

A primary tenet for professional societies is to advocate for their members and the consumers who are served by such professionals. Currently, the profession of audiology is primarily represented by the ASHA and AAA, and still has numerous other specialty societies for specific interest groups such as private practice, educational, military, and veteran's administration audiologists. Historically, these organizations worked independently on advocacy initiatives. While multiorganizational support of legislation has occurred, it was not until 2019 that audiology organizations fully united in their advocacy efforts toward passage of the Medicare Audiologist Access and Services Act (MAASA) of 2019.

The objective of the present review is to examine current codified and statutory language regarding the practice and profession of audiology and discuss current and previous policy efforts to improve access to hearing and balance care services by providing a clearer definition of audiology as the federally recognized home for hearing and balance care.

STANDARD OCCUPATIONAL CLASSIFICATION SYSTEM

The SOC system is a labor classification system created by the U.S. federal government in 1977 and is maintained by the Bureau of Labor Statistics.[11] The SOC provides a unified system for defining occupations and subsequently classifies workers to provide data for monitoring trends, including occupational regulation and scope. In 1977, the profession of audiology was represented solely by the ASHA. Audiologists were designated in the SOC system with speech-language pathologists as "therapists," but did not hold a distinct professional category. Implications of an inaccurate SOC definition extend beyond the validity of population-based data gathered for monitoring activities and affect how audiologists are classified within federally sponsored healthcare organizations and programs, such as Medicare or Medicaid.

Barry Freeman, Ph.D., was among the first audiologists to recognize this little-known code system and its contribution to the recognition of audiology as a distinct profession and specialty, separate from speech-language pathology. With no distinct SOC code for audiology, the profession did not exist to the federal government or other private entities, such as insurance companies, who use SOC codes to identify and gather data about professions.[11] Being classified with speech-language pathologists made it difficult to define the role of audiologists within the healthcare system.

In 1995, an initiative led by audiologist (and president of the AAA at the time) Carol Flexer, Ph.D., and the AAA organization resulted in the revision of audiologists' designation within the SOC.[12] The initial efforts afforded the creation of a separate category for "Audiologist" under the "Therapist" heading. The goal was to move audiology into the broad category of "Healthcare Practitioners and Technical Occupations" subcategory "Healthcare Diagnosing or Treating Practitioners."[12] Other practitioners in this category had clinical doctoral degrees like M.D. and D.O.[13] The clinical entry-level professional degree designations for audiologists in 1995 were Masters of Arts (M.A.), Masters of Science (M.S.), or Doctor of Philosophy (Ph.D.)[1] As the Doctor of Audiology (Au.D.) degree became a reality, achieving this change in designation also was realized. In 2010, after multiple meetings between the AAA and the Department of Labor and Bureau of Statistics, advocating with Members of Congress, and letters to government agencies, the profession of audiology was reclassified as a separate occupation category (29–1180 audiologists) in the major group labeled healthcare practitioners and technical occupations (29–0000), subcategory healthcare diagnosing or treating practitioners (29–1000).[13]

With this new designation, audiologists are defined as those who "Assess and treat persons with hearing and related disorders. May fit hearing aids and provide auditory training. May perform research related to hearing problems."[14] The Bureau of Labor Statistics' definition of audiologists still merits attention as it does not reflect the current scope of practice of audiologists. Licensing and regulation of audiologists in all 50 states now include assessment and audiologic management of hearing, tinnitus, auditory processing, and vestibular disorders as being within the scope of practice for audiologists.

THE SOCIAL SECURITY ACT AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

The SSA of 1935 was passed by the 74th U.S. Congress as part of a broader legislative agenda focusing on relief, recovery, and economic reform and security programs under President Franklin D. Roosevelt, commonly referred to as the Second New Deal. The SSA created the first federally sponsored social support programs, which provided aid to the unemployed, disabled, economically disadvantaged, and retired adults. These were among the first legislated actions to place the U.S. federal government as a steward of resources to assure protections for Americans to have securities for basic needs for survival (e.g., housing, food). In keeping with ideals of social support, barriers to healthcare access among retired adults became apparent as costs continued to increase as adults lived longer and healthier lives. It was because of this express need and well-documented financial healthcare burden among older adults that Medicare was established in 1965 as the

first federally operated, nationwide healthcare program in the United States.[15]

Medicare was created through the Title XVIII amendment to the SSA and provided health insurance for adults aged 65 years and older as well as adults with certain disabilities. Medicare is financially underwritten by the federal government of the United States and executed by the Centers for Medicare and Medicaid Services (CMS), which is the largest insurer of Americans. The CMS' coverage determinations are codified into federal law and are usually based on the federally accepted definitions and classifications of healthcare professions. As the largest insurer of Americans, CMS coverage policies often serve as the model for private payers, such as employer-sponsored healthcare insurance companies.

Physicians and nonphysician providers naturally have different diagnostic and procedural code sets available to them for billing and reimbursement under the Medicare Physician Fee Schedule. The Medicare Physician Fee Schedule is the complete listing of maximum fees CMS will reimburse a physician or other healthcare provider for a covered service. Nonphysician providers vary widely in their covered code sets, which usually reflect the types of services being provided. Recognizing that audiologists have a different job function compared with (speech or occupational) therapists, this vital pursuit of "practitioner status," a status already held by other nonphysician specialties such as nutrition and clinical social work, would better embody audiologists' clinical work activities of evaluation and audiologic management of hearing and balance disorders. Currently, audiologists are not recognized providers of evaluation and management services and thus do not have access to respective code sets under Medicare benefit policy.[16] Yet, evaluation and management activities are required for audiologists through the CMS's Merit-based Incentive Payment Scale, or MIPS, quality payment program.[17] The narrow classification of audiologists as suppliers of "other diagnostic tests" in the SSA limits the administrative changes CMS can make to reimburse audiologists for these types of services within their scope of practice.

For audiologists, covered services through CMS are limited to their statutory definition within the SSA. Audiology services are covered through Medicare under the "other diagnostic tests" provision under Section 1861(s)(3) of the SSA, making them payable under the Medicare Physician Fee Schedule.[16,18] Currently, Medicare provisions in the SSA primarily provides coverage for diagnostic services including the evaluation of hearing, tinnitus, and vestibular function, as well as for programming of prosthetic devices (implantable hearing devices such as cochlear implants). Medicare policy specifically excludes hearing aid provision as well as diagnostic assessment for the purpose of obtaining or fitting a hearing aid, which is unfortunate considering that hearing aids are the most widely used and efficacious treatment for age-related hearing loss.[19]

There are additional barriers for Medicare beneficiaries who seek hearing and balance services. Medicare coverage for audiology services requires two items: medical necessity (e.g., new signs and symptoms, disruptions in daily life, and safety) and a physician order.[16] Many other plans, including those sponsored by the federal government (e.g., the Department of Defense Medical Health System, the Veterans Health Administration, the Office of Personnel Management, and through the Federal Employee Health Benefit Plan) allow beneficiaries to access audiologists' services directly and do not require a physician order. This is also true of many other private health plans.

The present classification of audiologists by CMS is incongruent with the plethora of evidence demonstrating positive healthcare outcomes as a result of audiologic service provision (e.g., hearing aids, auditory training, tinnitus management, audiologic (re-)habilitation, and nonmedical vestibular management). Statutory noncoverage determinations also act as barriers to timely and meaningful access to hearing and balance care for older adults who are disproportionately affected by these issues.[4,20,21] The method by which the federal health policy classification of audiologists could be changed is through an amendment to the SSA, which depends exclusively on congressional support.

POLICY EFFORTS TO ADDRESS STATUTORY BARRIERS TO HEARING AND BALANCE CARE

Direct Access

On July 22, 2003, the Hearing Health Accessibility Act of 2003 (H.R. 2821) was first introduced by Representative Jim Ryun (R-KS) with original co-sponsor, Lois Capps (D-CA), during the 108th Congress.[22] The bill sought to amend Title XVIII of the SSA to provide Medicare beneficiaries the option to directly seek care from an audiologist for covered hearing and balance diagnostic services. The bill gained considerable success and visibility with more than 50 cosponsors in the House. A companion bill (S. 1647) was introduced by Senator Ben Nighthorse Campbell (R-CO) and original cosponsor Senator Tim Johnson (D-SD) on September 24, 2003, and gained three additional cosponsors during the congressional session.[23]

The Hearing Health Accessibility Act of 2003 sought to unify federal coverage policy under Medicare without changes to the scope of practice of audiologists. The bill, if enacted, would have aligned Medicare coverage policy with other federally supported healthcare plans (e.g., Veteran's Health Administration and Federal Employee Health Benefit Plan). Eliminating the need for obtaining a physician order would have afforded Medicare beneficiaries with timely access to audiology services without significant risk to health.[24]

The AAA, ASHA, and Academy of Doctors of Audiology (ADA) pledged uniform support for direct access legislation until policy agendas diverged in the early 2010s.[25] The Academy of Dispensing Audiologists (association name later changed to Academy of Doctors of Audiology [ADA] in October 2006) abandoned direct access efforts in November 2012 when it shifted its support to a legislative initiative that would amend Title XVIII of the SSA by 2018 (proposed legislation coined 18×18, discussed later). The ASHA subsequently abandoned support of the Hearing Health Accessibility Act in 2011, siding in favor with the ADA and AAA regarding expansions of Medicare coverage of audiologic services. The AAA continued to pursue direct access legislation with various sponsors through the 113th Congress. The last introduction of direct access legislation was the Access to Hearing Health Care Act (H.R. 4035, S. 2046) in the 113th Congress in February 2014.[26,27]

Expansion of Medicare Coverage for Audiologic Services

In 2013, the ASHA focused their audiology advocacy efforts on expanding Medicare coverage to the full scope of audiology practice. On June 12, 2013, Representative Gus Bilirakis (R-FL) introduced H.R. 2330, the Medicare Audiology Services Enhancement Act of 2013.[28] H.R. 2330 was intended to provide Medicare coverage for treatment services such as auditory rehabilitation and auditory processing services, vestibular treatment, and intraoperative neurophysiologic monitoring. The legislation did not specify coverage for other common treatment services provided by audiologists such as cerumen management and tinnitus treatment. This bill was controversial and if passed, would have required physician oversight for a treatment plan designed by audiologists. The bill did not find significant support from the AAA or ADA because of the physician oversight component. The AAA continued to advocate for improved access to audiologists for Medicare recipients by eliminating the physician order requirement and would not support legislation requiring physician oversight. The ADA stated they could not support legislation that would undermine both patient choice and the autonomous practice of audiology.[25]

H.R. 2330 was strongly supported by the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), the professional society representing otolaryngologists.[29] In their letter of support to Representative Bilirakis, AAO-HNS leadership indicated their support was based on the legislation's retention of physician referral requirements and recognition that physician oversight is a critical aspect of quality hearing healthcare services.[30] This bill was reintroduced by Representative Bilirakis in 2015 with continued opposition from the AAA and ADA.[31]

18 × 18 Initiative

In November 2012, the ADA launched an initiative at their annual convention to amend Title XVIII of the SSA by 2018, or 18 × 18 initiative.[32] Two of the objectives of the 18 × 18 initiative, direct access and expanded Medicare coverage for audiology services, were being similarly pursued by the AAA and ASHA as previously described. Notably, the 18 × 18 initiative was the first example of an audiology organization proposing pursuit of physician status under Medicare.

On July 31, 2014, H.R. 5304, the Audiology Patient Choice Act of 2014, was introduced for the first time.[33] H.R. 5304 legislation would have (1) afforded audiologists with Limited License Physician status, thereby categorizing audiologists as physicians for purposes of furnishing audiology services under the Medicare program; (2) eliminated the need for a physician order for Medicare beneficiaries to receive coverage of medically necessary, covered audiological and vestibular services; and (3) allowed for Medicare coverage of medically necessary, covered treatment services such as vestibular rehabilitation, cerumen removal, and aural rehabilitation when provided by a licensed audiologist practicing within their state-defined scope of practice.[33]

The last nonphysician provider group to obtain full physician status under Medicare was Optometry.[34] The American Optometric Association's 20-year pursuit to allow payment for vision care services performed by optometrists if already covered when furnished by a physician became a reality on October 21, 1986, when President Ronald Reagan signed in the 1987 federal budget.[35] This Medicare provision for optometric vision services became effective in April 1, 1987.[34] The CMS policy manual defines a physician as a:

> doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in subsection §70.2), doctor of podiatric medicine (within the limitations in subsection §70.3), or doctor of optometry (within the limitations of subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.[36]

Direct access legislation was opposed by the AAO-HNS as the group maintained this legislation was an expansion of the audiologists' scope of practice and limited physician oversight of the audiologic diagnosis and treatment process.[29] The Audiologist Patient Choice Act of 2014 received even stronger opposition by AAO-HNS deeming it even farther reaching than direct access. The AAA, after careful review of the proposed legislation in coordination with legislative and health policy experts, determined that the AAA leadership would continue to support more pragmatic and realistic legislative approaches to redefining audiology in federal code. ASHA remained publicly silent on the issue of H.R. 5304.

The Medicare Audiologist Access and Services Act

In early 2019, the AAA, ADA, and ASHA worked collaboratively to develop legislation that would expand access to and coverage for audiology services for Medicare beneficiaries. This single legislative strategy benefiting consumers and patients reflected the first unified legislative approach for audiology services since 2011. The legislative language that resulted was a combination and compromise of organizations' prior efforts.

With support from the AAA, ADA, and ASHA, the MAASA of 2019[37,38] was first introduced in the 116th Congress (H.R. 4056, S. 2446) and was later reintroduced as the MAASA of 2021[39,40] (H.R. 1587, S. 1731), on March 3, 2021, World Hearing Day. The proposed language in the MAASA would amend Title XVIII of the SSA by reclassifying audiologists as "practitioners" under Medicare and would align audiologists with other nonphysician healthcare providers such as physician assistants, nurse practitioners, clinical psychologists, and clinical social workers.[39,40] Such a designation would allow increased access to services for Medicare beneficiaries and provide

audiologists with opportunities to provide services consistent with their scope of practice, as defined by state licensure law.

The proposed legislation also has provisions that would alleviate delays in care and associated financial burden to the patient and Medicare system. It proposes to lift the physician order requirement for accessing audiologic services. Additionally, any services deemed to be medically necessary including vestibular rehabilitation, cerumen removal, and aural rehabilitation would be covered when provided by audiologists.[39,40] Currently, these services are covered by Medicare when delivered by physicians or other qualified healthcare professionals.[16] They are not covered when provided by audiologists due to the narrow definition of audiologists and covered audiology services in the SSA.[18] All of these services are within the scope of audiology practice and would statutorily reflect that audiologists are often the primary providers of these services.

Currently, CMS defines "audiology services" under Medicare as "hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician."[18] The MAASA proposes this language be replaced with:

> "diagnostic or treatment services furnished by a qualified audiologist which the qualified audiologist is legally authorized to perform under State law (or the regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician or as an incident to a physician's service, without regard to any requirement that the individual receiving such audiologist services is under the care of (or referred by) a physician or other health care practitioner or that such services are furnished under the supervision of a physician or other health care practitioner."[39,40]

DISCUSSION

Over the past two decades, various legislative initiatives have been pursued to increase patient access to and expand coverage for audiology services. Lack of unified goals among audiology societies was prohibitive to legislative advancement of many of these efforts. The new MAASA legislation provides an example of a well-coordinated and unified effort to address statutory barriers to hearing and balance care through Medicare.

The only aspect that remains fully unchanged from prior legislation is direct access to audiology services for all Medicare beneficiaries. This component would eliminate the need for a physician order for medically necessary, covered audiological and vestibular services.[39–41] Distinct from previous efforts, the MAASA legislation abandons any language related to Limited License Physician status for audiologists. Instead, pursuit of practitioner status in the MAASA legislation more closely aligns the profession of audiology with nonphysician providers such as physician assistants, nurse practitioners, certified registered nurse anesthetists, clinical psychologists, and clinical social workers.[36]

Medicare coverage for treatment services was the focus of the ASHA's legislative efforts beginning in 2011 and continued with the Medicare Audiology Services Enhancement Act of 2013. The Medicare Audiology Services Enhancement Act of 2013 required physicians' oversight of treatment plans, while the comprehensive Medicare benefit within the MAASA of 2021 allows for Medicare coverage of medically necessary covered treatment services but does not require physician involvement in concept or approval of treatment plans. MAASA includes Medicare coverage for treatment services such as vestibular rehabilitation, cerumen removal, and aural rehabilitation provided by audiologists when they are practicing within their defined scope of practice dictated by their state licensure laws. This legislation provides autonomy for audiologists to develop and deliver nonmedical treatment plans they develop with their patients.

The AAO-HNS strongly opposed direct access legislation when first introduced in 2003 through final introduction in 2014 and also strongly oppose the MAASA legislation due to concerns of patient safety.[42] They state, "Hearing and balance disorders are medical conditions that require a full patient history, physical

examination, and medical diagnosis by an MD/DO."[42]

In 2010, Zapala and colleagues addressed the patient safety issue in a retrospective chart review at the Mayo Clinic in Jacksonville, Florida.[24] The sample consisted of 1,550 records from a 1-year period. Treatment plans were reviewed by audiologists, otolaryngologists, and neuro-otologists. Results indicated that 95% of the patients required audiological services, and in most cases were the only services needed.[24] The treatment plans developed by the audiologist did not differ substantially from the otolaryngologist for the same condition, and there was no evidence supporting the notion that audiologists missed significant symptoms of otologic disease, and strong evidence that the audiologists referred patients to otolaryngology when appropriate. Additionally, the authors stated that:

> "under the most conservative assumptions, greater than 89% of Medicare beneficiaries complaining of hearing loss would not be expected to have active otologic disease or medically treatable conditions affecting hearing. They have presbycusic related hearing loss, for which audiological evaluation and management services best address the presenting complaints."[24]

Zapala and colleagues concluded that their findings were consistent with the premise that "audiology direct access would not pose a safety risk to Medicare beneficiaries complaining of hearing impairment."[24]

Veterans seeking hearing and balance services through the Veteran's Health Administration and beneficiaries of the Federal Employee Health Benefit Plan can obtain services directly from an audiologist without a physician order. Under the Federal Employee Health Benefit Plan, audiologists are directly reimbursed for these services. Neither the Veterans Administration nor the Federal Employee Health Benefit Plan has reported patient safety concerns when audiologists practice at the full scope of their practice and within the ethical behavior required by their state licensure laws.

A study commissioned by the AAA by Dobson, Davanzo, and Associates, LLC, a health economics and policy consulting firm, analyzed Medicare claims from 2007 to 2009 across all sites of audiologic service.[43] They compared patient outcomes and Medicare payments for beneficiaries who received audiological services from audiologists to those who received the services from other specialties. In their 2012 executive summary, the firm concluded that for acute and chronic hearing loss and vestibular conditions, neither patient care nor safety would be compromised if direct access legislation was passed.[43] The Dobson report and scientific evidence provided by Zapala and colleagues did not support the argument of AAO-HNS opposition based on safety concerns.

Changes proposed in the MAASA would allow Medicare beneficiaries the ability to seek services directly from an audiologist, improving their access and reducing the burden of unnecessary physician visits. Practitioner status would also allow Medicare beneficiaries the option to seek appropriate telehealth services from an audiologist and have those services covered, putting audiologists in a category similar to other nonphysician healthcare providers. Finally, the MAASA legislation would allow audiologists to function at the full scope of their licensure, allowing Medicare beneficiaries the ability to receive medically necessary treatment and services from the same professional who has evaluated them.

While the MAASA legislation amends Title XVIII of the SSA and directly impacts coverage for audiologic services among Medicare beneficiaries, the legislation could also influence how consumers of all ages access and receive these same services. Historically, many private payers follow Medicare coverage policies. This could improve access to hearing and balance care across the lifespan, ultimately reducing the negative consequences of untreated hearing and balance disorders in the United States.

CALL TO ACTION

Legislative efforts should assure that Medicare beneficiaries have access to hearing care services that contribute to overall well-being and meaningful functioning and productivity within

communities as they live longer and healthier lives. The MAASA legislation represents the best opportunity in more than a decade to amend the SSA and provide greater access to hearing and balance services for Medicare beneficiaries. The MAASA provisions include direct access to audiologic services, recognition of audiologists as providers of the hearing and balance care, coverage for management of diagnosed auditory and balance issues under the Medicare Physician Fee Schedule, as well as redesignation as practitioners under the SSA. The MAASA constitutes an attainable path to address statutorily poor access to hearing and balance care among a growing demographic of older adults and has far-reaching implications for other payers, many of who follow Medicare coverage policy.

Continued involvement in the legislative process is crucial to advancing health policy to improve access to hearing and balance care in the United States. Readers are encouraged to engage in communications with elected and appointed federal officials, as well as state-level policy makers to express a need for change and provide examples on how to address inadequacies, such as the MAASA legislation. Other relevant stakeholders (e.g., patients, families, and patient advocacy groups) also should be engaged in the legislative process to provide support and perspective to successfully address statutory barriers that impede timely access to care for a growing number of Americans with hearing and balance disorders.

CONFLICT OF INTEREST
No disclosures to report.

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