STATEMENT OF ROBYNNE KRATCHMAN, PRESIDENT
NEW JERSEY SPEECH-LANGUAGE-HEARING ASSOCIATION (NJSHA)
ON TELEMEDICINE/TELEHEALTH
PRESENTED BEFORE THE SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE
OCTOBER 27, 2020

Good afternoon, Chairman Vitale and members of the committee. My name is Robynne Kratchman and I am the president of the New Jersey Speech-Language-Hearing Association (NJSHA). We represent over 1,500 speech-language pathologists and audiologists in the state and work to advocate for their interests and that of the patients and students we serve. I am also the Director of Speech-Language-Pathology Programs at Speech and Hearing Associates, one of the largest private practices in the state serving individuals with speech and hearing issues.

NJSHA worked with you as you fashioned the legislation that became P.L. 2017, c. 117, which provides the framework for all health care providers to utilize telemedicine. With the onset of the COVID-19 pandemic earlier this year, telemedicine exploded as the vehicle to provide care to patients. Speech-language pathologists (SLPs) and audiologists were grateful to have the 2017 law in place to provide structure as we moved toward remote care. At the same time, some unexpected issues became readily apparent.

The 2017 law mandates that insurance carriers provide ***coverage parity*** for services provided via telehealth, the same as in-person visits. However, regarding, ***reimbursement rate*** it says that it must be provided "at a provider reimbursement rate that ***DOES NOT EXCEED*** the provider reimbursement rate that is applicable, when the services are delivered through in-person contact and consultation in New Jersey." Essentially, carriers do not have to reimburse at the same rate – all they have to do is ***not EXCEED*** it. At my practice, prior to the emergency COVID-19 related legislation that required reimbursement for telehealth to be the same as in office services, certain carriers had informed us that they will be reimbursing teletherapy at a rate of 40% of an in-person visit. THIS RATE IS WELL BELOW WHAT IT COSTS TO PROVIDE THE SERVICE! As a participating provider I am obligated to provide this covered service but it is unsustainable at this rate.

Reimbursement for speech therapy is tied to CPT codes. The codes for speech therapy are not time based. That means the reimbursement is the same for a session that lasts 15 minutes as it is for a session that lasts an hour. Unlike other therapy services, speech therapy has one CPT code, thus there is no option to combine codes in order to achieve a higher reimbursement. Further, many insurance plans place annual limits on the number of speech therapy sessions that

will be covered for an individual. Thus, from the perspective of the insurance plans, it should not make a difference as to the place of service, i.e., in office, in home, in daycare or by teletherapy. The insurance company's liability has a maximum amount. In teletherapy, the SLP is providing the same service as if in person. In fact, teletherapy requires the same level of expertise, level of skill and actually requires more planning and preparation time by the SLP. Paying the provider less for a teletherapy session seems disingenuous as it is the same service just provided in a different, and equally effective, manner. Further, teletherapy won't increase utilization, as there would be the same number of visits allowed by insurance plans, no more nor less. However, used appropriately, it can increase consistency and outcomes.

It seems appropriate to point out that even though the 2017 Act is clear that insurance carriers must cover speech-language pathology and audiology services provided via telehealth, at the onset of the massive shift to telehealth due to COVID-19, we found that carrier representatives had been telling our billing personnel that they would no longer be providing coverage for telehealth on several different arbitrary dates. Our personnel have informed them of the 2017 Act and the fact that coverage is mandated. While this is resolved during the public health emergency (PHE), we wish to ensure that the law is consistently followed once the PHE is over.

Another barrier that has come up has to do with many insurance representatives advising SLP providers that in order for teletherapy to be covered, the patient must access it via a specific telemedicine platform such as American Well, TeleDoc and MDLive. These platforms have no SLPs on their panel. In fact, I reached out to each one and was told that as a licensed, certified SLP I could not participate. These platforms are in fact, solely for medical services of a physician, nurse practitioner and licensed clinical social worker or psychologist. Thus the requirement that teletherapy is only accessed through these platforms is an insurmountable barrier to provide speech therapy via telehealth.

I would like to point out that the platform issue as well as the coverage parity issue discussed earlier in my testimony are addressed in S2559, sponsored by Senator Gopal and NJSHA thanks him for introducing this legislation.

I do want to explain that teletherapy, as practiced by SLPs, involves synchronous audio and visual interaction. These are not simply telephone consults but robust, interactive, real-time treatment interventions that continue to meet the patients' established plans of care. Teletherapy has proven to be of great benefit during this pandemic during stay-at-home orders and social distancing requirements in place. Patients that would have been without therapy for over seven months have successfully avoided regression. In addition, we have seen with COVID-19 that those receiving therapy by teletherapy have had more consistent attendance thus many are progressing more rapidly and are more likely to reach their goals more quickly. Thus, in some cases, teletherapy could shorten the duration of treatment and potentially cut costs.

As the state hopefully continues to re-open, there will be populations who will choose to keep limiting their exposure. This includes families who have medically fragile children or adults. For example, children with compromised autoimmune systems such as those with CP are at higher risk for respiratory diseases and the need to stay virtual is critical. Adults who have had strokes, and require critical therapy to regain speech, are in the high-risk population. For all these individuals, being able to continue to access therapy through teletherapy is truly important to their well-being.

During the practice of in person speech therapy, it is often difficult or counterproductive to maintain the recommended social distance and/or wear facial coverings that hide the lips, tongue and teeth. There are many special needs children that simply cannot tolerate wearing a mask at all. Adults with hearing compromises often have difficulty understanding speech when the speaker has a face covering. For them and for their SLPs, remote therapy is safest. Teletherapy serves to increase patient access, maintain quality care, and allow more functionally based services due to more family involvement and individualized life centered goals are critical.

The provision of health care via telehealth was expected to unfold over time with many opportunities to work out the kinks. COVID-19 expedited and changed everything for the foreseeable and probably distant future. NJSHA greatly appreciates your attention to this issue which will help to make telemedicine/telehealth work best for everyone involved, most importantly, our patients.

We appreciate the hard work you have done to address the best interests of our patients most of all.

Supporting documentation:

Exhibit A: Sourced from: https://www.asha.org/articlesummary.aspx?id=8589984232

Diversity of Practices in Telerehabilitation for Children With Disabilities and Effective Intervention Characteristics: Results From a Systematic Review

Camden, C., Pratte, G., et al. (2019).
Disability & Rehabilitation, 1-13.

This article is from a systematic review of experimental randomized trials investigating the effectiveness of providing rehabilitation via telepractice to children with disabilities and their families. The purpose of the study was to describe the characteristics and effectiveness of pediatric telerehabilitation interventions offered to children 0–12 years old or to their families" (p. 2). The review included 23 studies from January 2007 to March 2018. The following are some excerpts from the findings:

For children with disabilities receiving intervention via telepractice, "many studies reported high adherence rates and satisfaction with telerehabilitation, which is coherent with other qualitative studies that explored parental satisfaction" (p. 10).

For children with disabilities receiving intervention via telepractice, the type of technology used (e.g., videoconferencing, phone, email) did not influence outcomes indicating a multimodal approach can be adapted to fit the needs of the children and their families.

For children with disabilities receiving intervention via telepractice, "using a coaching approach was identified as being more frequently associated with outcome improvement" (p. 9), particularly when coaching supported parent-implemented home programs. Direct child participation did not result in greater effectiveness of telerehabilitation. "Our results demonstrate that telerehabilitation might be as effective as face-to-face interventions" (p. 10).

For children with disabilities receiving intervention via telepractice, scheduled online intervention sessions as compared to a needs-based approach (e.g., family contacts the provider on an as-needed basis) were found to be more effective.

Exhibit B:

Statements from speech-language pathologists regarding the efficacy and outcomes of teletherapy:

CW: I found that teletherapy has been crucial for low functioning/nonverbal students and patients as they generally thrive on routine and structure. Just being accountable for sitting and attending to a session is super important. We are still able to use some of the same strategies as in person such as breaks, timers and other reinforcement tactics to increase motivation. I found that children who have not been attending teletherapy during all of these months have significantly regressed and will require excessive therapy and ABA to regain those skills to just sit and attend to a therapy session let alone learn and make progress towards goals.

I also find many of my articulation only patients have made significant gains. Attendance has been much higher on teletherapy and parents are able to listen in on the session making it easier for them to correct sounds or practice at home. I am flying through goals with my articulation only clients.

I just feel overall it should be an option for patients and families at all times because instead of cancelling a session, it provides an opportunity to continue therapy if he/she is unable to come into the office (once everything is fully reopened).

MS: When provided teletherapy, I was able to continue treatment for those patients who are immune compromised. One, in particular, a young pre-school aged boy who suffers from respiratory difficulties. He was significantly speech delayed and unfortunately due to his illness, he often cancelled or couldn't attend "in person" sessions prior to COVID. Since teletherapy became available for him, he hasn't missed a session and with the consistent therapy sessions he is now chatting it up!

AA: A few thoughts from my experience as to why teletherapy is beneficial-- some children find interactions via teletherapy to be more "fun" for them which improves their motivation to participate (can be opposite effect as well but this is the case for at least some children), teletherapy is better for parents that previously at times had transportation issues or inclement weather issues but can now continue consistency with weekly sessions and lastly sometimes I feel that with teletherapy the whole family is able to be involved more with awareness, practice and carryover because they have more of a chance of tuning into some of the session instead of the same parent bringing them every week to the office

AM: One of my clients is a 9 year old autistic boy who before COVID we spent about half of each session (1x per week because of scheduling on both sides) managing behavior. He spoke in short sentences and had difficulty carrying on a conversation. During COVID we were able to do 4 teletherapy appointments a week and his progress was wonderful! Now he works for the full 30 minutes most days, engages in meaningful conversations with me, uses a wide variety to vocabulary and sentence structure and is

always focused and ready to learn more! Mom was able to attend more sessions and see how we were working in order to help carry over at home.

-I was able to discharge two articulation clients who were kind of stuck because they couldn't generalize into different environments but since they were now doing the therapy in the home it was easier to carry the skills into the home and with family

- With teletherapy I am able to see into children's home life which has helped understand/manage behavior, choose appropriate targets. For those clients who go between 2 homes, I have been able to communicate more with both parents and get a new perspective on the client in order to provide better therapy

- It has been great to be able to work with a client earlier in the day vs. having to wait until a parent gets to pick them up and bring them to therapy, etc – I am able to see the children when they are well rested and more mentally prepared for focusing on skilled therapy

CC: 1. Teletherapy has been really useful in all situations where my patients could not get to the office- not just because of COVID. Our adult and pediatric patients lead busy lives and sometimes things don't work out as planned. I've had many patients get stuck in traffic, parents get caught up at work, et cetera, and instead of cancelling the session, we have been able to change the appointment to teletherapy and it has worked out great! As clinicians, we know that consistency of therapy is crucial to progress, and teletherapy allows us a viable alternative to in-person therapy when things get crazy and our patients start to have trouble keeping their weekly appointments. Even when we had a hurricane and I was stuck at home, I was able to complete some teletherapy sessions. My patients and I stayed safe without compromising their progress by skipping a week of therapy. I envision this being useful in the winter months when inclement weather is likely to impact patients' abilities to arrive at our office safely and punctually. Further, as one of the therapists who works with a specialized area (voice), the availability of teletherapy allows more patients to receive the care they need in order to live their fullest lives. I wonder if my voice patient would even bother coming to voice therapy week after week if she was told that she had to drive over an hour for therapy every week.

2. An added benefit of teletherapy is that we are afforded a glimpse into the home environments of our patients. Because of teletherapy, I really know how the parents of my early intervention patients are interacting with them and the types of toys the kids gravitate to at home. With that knowledge, I have been able to better counsel the parents that I work with on how to facilitate communication in their natural environments. The progress has spoken for itself.

SB: I have a couple of patients who are able to complete sessions because they don't need to spend the time traveling. By the time they would get to the office it would be too late to have productive sessions. They can also come twice a week because it's teletherapy which wouldn't happen if it was in person.

MW: Teletherapy has allowed some of my parents to keep their child on track while unable to leave their home because of sick siblings and/or because of their work . This is probably a very common response from many of the therapists, but it has been a very big support in having the children stay on target rather than miss and experience regression in many cases, thereby lessening the overall time in therapy. Even my non-verbal children have benefitted from the continuity that teletherapy has allowed with no interruption of services and much more parental involvement keeping them engaged along with the therapist.

Exhibit C:

ASHA information on appropriateness of telepractice for various disorders, as well as considerations for best practice

https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934956&section=Key_Issues#Reimbursement

Numerous studies have looked at the efficacy of telepractice for a variety of clinical disorders.

https://www.asha.org/EvidenceMapLanding.aspx?id=8589944872&recentarticles=false&year=undefined&tab=all

From ASHA letter in support of expanding telepractice coverage:

A recent study from Children's Hospital of Philadelphia, including speech-language pathology services, demonstrated that 86% of patients and caregivers were interested in continuing to receive future care via telehealth.[i] The clinical teams involved found telehealth to be clinically appropriate and effective 93% of the time.[ii]

Research demonstrates the efficacy of telehealth and its equivalent quality as compared to in-person service delivery for a wide range of diagnostic and treatment procedures for adults and children.[iii] Studies have shown high levels of patient, clinician, and parent satisfaction supporting telehealth as an effective alternative to the in-person model for delivery of care.[iv] This reinforces that only clinically appropriate delivery or use of telehealth by audiologists and SLPs must be equivalent to the quality of services provided in person in order to remain in compliance with ASHA's Code of Ethics.[v]

---

[i] Rametta, S. C., et al. (2020). *Analyzing 2,589 child neurology telehealth encounters necessitated by the COVID-19 pandemic. Neurology*. 10.1212. https://n.neurology.org/content/early/2020/06/09/WNL.0000000000010010.
[ii] Ibid.
[iii] Grogan-Johnson, S., Alvares, R., Rowan, L., & Creaghead, N. (2010). A pilot study comparing the effectiveness of speech language therapy provided by telemedicine with conventional on-site therapy. *Journal of Telemedicine and Telecare*, 16, 134–139.
[iv] Ibid.
[v] American Speech-Language-Hearing Association. (2016). *Code of Ethics*. https://www.asha.org/Code-of-Ethics/.