Advocacy in Action:

Negotiating for Increased Medicaid Rates and Coverage

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

General Information

Advocacy in Action: Negotiating for Increased Medicaid Rates and Coverage is published by the American Speech-Language-Hearing Association (ASHA) as a resource for state speech-language and hearing associations and state leaders. It provides details on how to develop an effective state advocacy program for increasing coverage of and reimbursement for speech-language pathology and audiology services by Medicaid. Opinions contained herein do not reflect the official view of the American Speech-Language-Hearing Association.

Copies may be requested from:

ASHA Action Center
10801 Rockville Pike
Rockville, MD 20852-3279
800-498-2071
E-mail: actioncenter@asha.org

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Introduction

As part of the 2004 Health Care Focused Initiative, a team of ASHA National Office staff, with input from and consultation with member-experts in Medicaid financing, was established to develop a tool to assist state speech-language-hearing associations in advocating for increased coverage of and reimbursement for speech-language pathology and audiology services by Medicaid. This tool is based on information contained in the ASHA document Advocacy in Action: A State Model for Change, developed under the 2001–2004 Schools Focused Initiative, as well as regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) and other sources.

This document provides state associations and state leaders with selected information on the Medicaid program and key federal requirements, and an overview of suggested legislative and regulatory efforts.

The Medicaid program is a complex federal-state partnership that provides certain classes of individuals with health care coverage. Individual states have vast discretion in the implementation and administration of the Medicaid program. It is difficult to provide specific information on each state's Medicaid plan. Therefore, this document provides generic ideas on how to start and successfully continue an advocacy effort.

A proven technique in advocating for increased reimbursement is the use of other states' Medicaid rates and/or Medicare outpatient rates to provide the Medicaid agency with a better understanding of the value of speech-language pathology and audiology services. Therefore, state-specific Medicaid rates (where available), national fee data, and Medicare fee averages are listed in Section 3—Sample Advocacy Tools. These Medicaid data are based on information received from state associations and from state Medicaid Web sites and may not reflect current reimbursement rates. This information should be used strictly for comparison. The most up-to-date and state-specific reimbursement and coverage information can be obtained through your state's Medicaid agency.

Section One

The Medicaid Program: A Federal and State Perspective

Speech-language pathologists and audiologists are recognized as providers under the Medicaid program. Medicaid is a jointly funded program between the federal and state governments to assist states in providing medical care to low-income individuals and those who are categorized as medically needy. Each state administers its own program and establishes its own income eligibility standards; type, amount, duration and scope of services covered; and payment rates with review and approval by the federal Centers for Medicare and Medicaid Services (CMS).

A. The Federal Medicaid Program–Speech-Language Pathology and Audiology Requirements

Although states are provided great flexibility in offering Medicaid services to their constituents, they are required to do so under broad federal guidelines. Most states cover speech-language pathology and audiology services in some manner; however, they are not mandated by federal law to so do, with the exception of providing services to children under the age of 21. CMS, the federal agency responsible for interpreting and administering federal Medicaid laws, provides guidance to states through regulations, transmittals, and letters to states' directors (see http://www.cms.hhs.gov/states/default.asp).

Federal law requires that children under the age of 21 be provided services including audiology and speech-language pathology on a comprehensive basis through the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT). In 1997, Congress also passed the State Children's Health Insurance Program (SCHIP), which mandates coverage of services to children in low-income families even when the family's income exceeds Medicaid eligibility requirements.

CMS requires that audiologists and speech-language pathologists participating in the Medicaid program meet specific requirements

in order to qualify for payment. The regulations outlining provider qualifications for speech-language pathology and audiology services can be found in Chapter 42 of the *Code of Federal Regulations, 440.110*. The regulations specify that services, if offered by the state, will be covered if the providers meet the following qualifications:

> *Sec. 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.*
>
> *(2) A ''speech pathologist'' is an individual who meets one of the following conditions:*
>
> > *(i) Has a Certificate of Clinical Competence from the American Speech and Hearing Association.*
> >
> > *(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate.*
> >
> > *(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.*
>
> *(3) A ''qualified audiologist'' means an individual with a master's or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:*
>
> > *(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services.*
> >
> > *(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions:*
>
> *(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.*

(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

B. General Federal Requirements

As a condition of participating in the Medicaid program, states are required to cover certain populations and certain services. However, states have the option to cover other classes of individuals and services that are not required by law and receive federal funds to help pay for the cost of providing these services. Over half of Medicaid spending is for optional versus mandatory services.

1. Eligibility and Coverage

In order to qualify for Medicaid, individuals must demonstrate that their income and resources fall below a certain threshold. Qualification criteria vary from state to state because, within certain parameters, each state can establish its own eligibility requirements. The Social Security Act (SSA) requires state Medicaid coverage for those individuals who are referred to as "categorically needy." The categorically needy population includes the following:

- Low-income families with children who meet certain eligibility requirements
- Supplemental Security Income (SSI) recipients, or disabled individuals who meet criteria other than that approved in the state's Medicaid plan
- Infants born to Medicaid-eligible pregnant women
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the federal poverty level

For categorically needy individuals, the states are required by federal law to provide the following services:

- Inpatient hospital services
- Outpatient hospital services (rehabilitation as required for those under 21)
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for person aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health center services (FQHC), and ambulatory services of an FQHC that would be available for other settings

In addition to the required services listed above, states have the discretion of offering the following services to their categorically needy constituents:

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under age 21

- Transportation services
- Rehabilitation and physical therapy services
- Home and community–based care to certain persons with chronic impairments

States are also permitted to provide medical assistance to individuals and families whose income exceeds the Medicaid eligibility requirement; these individuals and families are known as the "medically needy population." States may allow those individuals meeting the medically needy criteria to receive Medicaid assistance by paying a monthly premium to the state.

2. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) for Children Under Age 21

Under EPSDT, Medicaid eligible children under the age of 21 qualify to receive a comprehensive package of benefits including screening and wellness checkups. There are four separate screenings required under EPSDT: medical, vision, hearing, and dental.

The medical screening must include at least the following five components:

- A comprehensive health and developmental history including assessment of both physical and mental health
- A comprehensive, unclothed physical examination
- Appropriate immunizations
- Lab tests
- Health education including anticipatory guidance

As part of the comprehensive developmental history, speech-language pathology and audiology services are included for 1) the identification of children with speech or language impairments, 2) diagnosis and appraisal of specific speech or language impairments, 3) referral for medical or other professional attention necessary for rehabilitation of speech or language impairment, 4) provision of speech and language services, and 5) counseling and guidance of parents, children, and teachers.

Medicaid coverage of audiology and speech-language pathology services is comprehensive. Chapter 42 of the *Code of Federal Regulations 440.110* states that—

> "Services for individuals with speech, hearing and language disorders means diagnostic, screening, preventative, or corrective services provided by or under the direction of a Medicaid qualified speech language pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law."

Included under this definition are any necessary supplies and equipment.

Federal law requires that each of the screenings must be performed at distinct intervals. These intervals are determined by periodic schedules that meet the standards of pediatric and adolescent medical and dental practice. States are required to report their performance information annually to CMS. Reported information includes the number of children screened and the number referred for corrective treatment.

In addition, EPSDT covers visits to a healthcare provider when needed outside of the periodic schedule—called interperiodic screens—to determine whether a child has a condition that needs further care. Persons outside the healthcare system (e.g., parents or teachers) can determine the need for an interperiodic screen. Any encounter with a healthcare professional acting within the scope of practice is considered to be an interperiodic screen, whether or not the provider is participating in the Medicaid program at the time the screening services are furnished.

Based on the results of the screening, states must provide any services that are permitted to be covered under Medicaid, that is, those necessary to treat or ameliorate a deficit, physical or mental illness, or a condition identified by a screen. States are permitted to establish the amount, duration, and scope of services provided under this benefit as long as the limitations are reasonable, and services are sufficient.

C. State Medicaid Requirements

State Medicaid agencies are responsible for administering the Medicaid program on a day-to-day basis. While states must operate within federal guidelines in order to receive federal matching funds, these guidelines give states broad flexibility in operating their programs. State Medicaid plans can vary tremendously from state to state in terms of coverage and administration of the program. State plans are developed with input from various sources including the legislature, the state's Medicaid advisory committee, healthcare professionals, and the healthcare community.

1. State Plans

CMS requires states to file a State Medicaid Plan, which outlines the policies of the state. There are 63 separate statutory requirements that state Medicaid plans must meet. CMS reviews the plans to ensure conformity with federal requirements.

Contact information for the 10 CMS regional offices that have direct oversight of state Medicaid program can be found at: http://www.cms.hhs.gov/about/ regions/professionals.asp.

Copies of state plans can be found on the CMS Web site at: http://www.cms.hhs.gov/states/default.asp or by requesting a hard copy of the document through the regional CMS office. Below are the topics that must be addressed in a state plan.

State Plan Requirements

1.0 SINGLE STATE AGENCY ORGANIZATION UNIT
- 1.1 Designation and Authority
- 1.2 Organization for Administration
- 1.3 Statewide Operation
- 1.4 State Medical Care Advisory Committee
- 1.5 Pediatric Immunization Program

2.0 COVERAGE AND ELIGIBILITY
- 2.1 Application, Determination of Eligibility and Furnishing Medicaid
- 2.2 Coverage and Conditions of Eligibility
- 2.3 Residence
- 2.4 Blindness
- 2.5 Disability

2.6 Financial Eligibility
2.7 Medicaid Furnished Out of State

3.0 SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services
3.2 Coordination of Medicaid with Medicare Part B
3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases
3.4 Special Requirements Applicable to Sterilization Procedures
3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries
3.6 Ambulatory Prenatal Care for Pregnant Women during Presumptive Eligibility Period

4.0 GENERAL PROGRAM ADMINISTRATION

4.1 Methods of Administration
4.2 Hearings for Applicants and Recipients
4.3 Safeguarding Information on Applicants and Recipients
4.4 Medicaid Quality Control
4.5 Medicaid Agency Fraud Detection and Investigation Program
4.6 Reports
4.7 Maintenance of Records
4.8 Availability of Agency Program Manuals
4.9 Reporting Provider Payments to the Internal Revenue Service
4.10 Free Choice of Providers
4.11 Relations with Standard-Setting and Survey Agencies
4.12 Consultation to Medical Facilities
4.13 Required Provider Agreement
4.14 Utilization Control
4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases
4.16 Relations With State Health and Vocational Rehabilitation Agencies and Title V Grantees
4.17 Liens and Recoveries
4.18 Cost Sharing and Similar Charges
4.19 Payment for Services
4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services
4.21 Prohibition Against Reassignment of Provider Claims
4.22 Third Party Liability

4.23 Use of Contracts
4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services
4.25 Program for Licensing Administrators of Nursing Homes
4.26 RESERVED
4.27 Disclosure of Survey Information and Provider or Contractor Evaluation
4.28 Appeals Process for Skilled Nursing and Intermediate Care Facilities
4.29 Conflict of Interest Provisions
4.30 Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals
4.31 Disclosure of Information by Providers and Fiscal Agents
4.32 Income and Eligibility Verification System
4.33 Medicaid Eligibility Cards for Homeless Individuals
4.34 Systematic Alien Verification for Entitlements
4.35 Remedies for Skilled Nursing and Intermediate Care Facilities That Do Not Meet Requirements of Participation
4.36 Required Coordination Between the Medicaid and WIC Programs
4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities
4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities
4.40 Survey and Certification Process
4.41 Resident Assessment for Nursing Facilities

5.0 PERSONNEL ADMINISTRATION

5.1 Standards of Personnel Administration
5.2 RESERVED
5.3 Training Programs; Subprofessional and Volunteer Programs

6.0 FINANCIAL ADMINISTRATION

6.1 Fiscal Policies and Accountability
6.2 Cost Allocation
6.3 State Financial Participation

7.0 GENERAL PROVISIONS

7.1 Plan Amendments
7.2 Nondiscrimination
7.3 Maintenance of AFDC Effort
7.4 State Governor's Review

D. Medicaid State Level Administration

Each state must appoint an agency to administer the program, which again will vary from state to state. CMS's Web site provides links to the appropriate lead agency for the state.

E. Medical Care Advisory Committee

All state Medicaid agencies are required to receive provider and beneficiary input on their Medicaid plan through a federally mandated Medical Care Advisory Committee. The Medicaid agency director must appoint a physician and other health professionals, a Medicaid beneficiary, and the director of public health or welfare agency to the Medical Care Advisory Committee. This committee must have an opportunity to participate in policy development and program administration. Most states provide information on upcoming meetings and minutes of past meeting on their Web sites.

F. Financing

Medicaid is a voluntary, open-ended, federal-state matching program. If a state elects to participate in Medicaid, it is entitled to receive matching funds from the federal government for the state's outlay of funds to purchase covered services. These federal matching payments are known as the federal financial participation (FFP). The FFP for covered services is determined by a formula that is tied to the state's per capita income. The federal matching rate, known as the federal medical assistance percentage (FMAP), varies from a minimum of 50 percent of the state's Medicaid outlay for high per capita income states to 77 percent in low per capita income states. (See Table 2 for the FMAP for FY 2004.)

Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages For Fiscal Year 2004

State	Federal Medical Assistance Percentage	Enhanced Federal Medical Assistance Percentage
Alabama	70.75	79.53
Alaska	58.39	70.87
American Samoa	50.00	65.00
Arizona	67.26	77.08
Arkansas	74.67	82.27
California	50.00	65.00
Colorado	50.00	65.00
Connecticut	50.00	65.00
Delaware	50.00	65.00
District of Columbia	70.00	79.00
Florida	58.93	71.25
Georgia	59.58	71.71
Guam	50.00	65.00
Hawaii	58.90	71.23
Idaho	70.46	79.32
Illinois	50.00	65.00
Indiana	62.32	73.62
Iowa	63.93	74.75
Kansas	60.82	72.57
Kentucky	70.09	79.06
Louisiana	71.63	80.14
Maine	66.01	76.21
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	55.89	69.12
Minnesota	50.00	65.00
Mississippi	77.08	83.96
Missouri	61.47	73.03
Montana	72.85	81.00
Nebraska	59.89	71.92
Nevada	54.93	68.45
New Hampshire	50.00	65.00
New Jersey	50.00	65.00
New Mexico	74.85	82.40
New York	50.00	65.00
North Carolina	62.85	74.00

North Dakota	68.31	77.82
Northern Mariana Islands	50.00	65.00
Ohio	59.23	71.46
Oklahoma	70.24	79.17
Oregon	60.81	72.57
Pennsylvania	54.76	68.33
Puerto Rico	50.00	65.00
Rhode Island	56.03	69.22
South Carolina	69.86	78.90
South Dakota	65.67	75.97
Tennessee	64.40	75.08
Texas	60.22	72.15
Utah	71.72	80.20
Vermont	61.34	72.94
Virgin Islands	50.00	65.00
Virginia	50.00	65.00
Washington	50.00	65.00
West Virginia	75.19	82.63
Wisconsin	58.41	70.89
Wyoming	59.77	71.84

[Effective October 1, 2003–September 30, 2004 (Fiscal Year 2004)]

Payments to Providers

States have great flexibility in how Medicaid payments are made to providers. They have the option of paying for covered services on a fee-for-service basis, through managed care arrangements, or through some combination of the two. States have broad discretion in establishing payment methodologies and setting payment amounts. Federal Medicaid laws do not establish a specific floor or ceiling on the payment rates for an individual provider. The only federal requirement regarding provider reimbursement is that the rates must be adequate to ensure that enough providers participate in the program to provide appropriate access to those eligible to receive Medicaid services. State payment methodologies are described in the state Medicaid plan.

G. Medicaid in the School System

Although Medicaid is a "medical" assistance program, it recognizes the importance of school-based speech-language pathology and audiology services. The federal Medicaid program actually

encourages states to use funds from their Medicaid program to help pay for certain healthcare services that are delivered in the schools, providing that federal regulations are followed. Approximately 75% of all Medicaid school-based services are provided by audiologists and speech-language pathologists.

Section 1903 (c) of the Social Security Act was amended in 1988 to allow Medicaid coverage of health-related services provided to children under the Individuals with Disabilities Education Act (IDEA). Part B of IDEA allows children with disabilities to receive special education and related services, such as speech-language pathology, when the services are recommended in the child's Individualized Education Program (IEP). CMS authorizes Medicaid reimbursement for some or all of the costs of health-related services provided under IDEA when the services are 1) provided to Medicaid-eligible children, 2) medically necessary, 3) delivered and claimed in accordance with all other federal and state regulations, and 4) included in the state plan.

H. Conclusion

Medicaid coverage policies vary from state to state, and a thorough understanding of how the state plan works is critical in understanding coverage of speech-language pathology and audiology services. It is also essential for speech-language pathologists and audiologists to understand federal guidelines. With an understanding of both the federal and state Medicaid programs, speech-language pathologists and audiologists can ensure that the services they provide adhere to the requirements of each.

Section Two

A Guide To State Advocacy

There are multiple steps a state association must take in order to implement a successful advocacy campaign. This section will explain the various actions a state association should consider when developing and implementing an advocacy campaign.

Step 1: Determining the Agents for Change

The first step is to assess your association's potential to achieve its regulatory or legislative goal. ASHA developed a criterion template (see page 20) that can be used to evaluate your state's historic progress on a variety of legislative or regulatory activities. By evaluating the factors favorable for success and analyzing factors that may be obstacles, you can determine your state's potential for legislative or regulatory advocacy.

Your state association may wish to consider the following questions when completing the criterion template.

- *History of issue:* Has your state association worked on this issue before? Have you had any success? If not, why?
- *Level of support or opposition from key decision makers at the state and local level:* Do you have support from key decision makers at the state level such as the governor, key legislators who have jurisdiction for your legislation, contacts in the state Medicaid agency, and state and local education agencies?
- *Lobbyist:* Does your state association have a paid lobbyist who has knowledge and experience with the state legislature or state decision making process? Does the lobbyist have a proven track record on the association's issues? What is the lobbyist's opinion about your chance for success at this time?
- *Communication system:* Does your state have an effective grassroots system in place to communicate with members? Do you have a state association Web site, listserv, or state newlsetter? Do you have a current database of members with accurate contact information including mailing addresses, telephone numbers, and e-mail addresses?

- *Priority of issue for the state association:* Is this issue a priority for your state association? Has the membership voted on priority issues for the association? Will your state association provide financial support necessary to sustain the effort?
- *Political climate:* What is the current political climate (e.g., budget concerns, state agenda, legislative calendar) for the state? What is the process to effect change in the state? Do you need to make a legislative or regulatory change, and are you certain that change must occur at the state level? Have you read and clarified the actual regulation or legislation that currently exists for your issue?
- *Other factors pertinent to your state or issue:* Are there other factors pertinent to your state that you should consider (e.g., recent political scandal or hot potato that would overshadow your effort)? Is the timing favorable for change? Are there data that you need to collect to support your decision?

The audit allows your state association to develop a clear and objective picture of the factors in your state influencing the issue and to decide if the issue warrants a state-level approach. First, you must determine where in your state the issue is controlled and determine your options for advocacy. This is not always as straightforward as you might think. If your state decides that the issue requires a state advocacy effort, then an organized plan of action is recommended.

The audit also enables your state to weigh the pros and cons or the support and opposition to the issue. To complete the audit, enlist the assistance of two or three state association members who (a) have experience and history with the issue, (b) are interested in participating in the advocacy effort, and (c) have knowlege of your state association governance.

The group completing the template can then evaluate the results to determine the areas of action needed and the potential for success. The State Criterion Template uses the following rating scale when assessing an issue in the states:

+ if the criterion factor was positive or had support,

0 if it was neutral, and

- if it was negative or there was opposition.

Tabulate the ratings to determine whether the "pluses" outweigh the "minuses" and whether a state approach is warranted or feasible. If the decision is made to move forward, proceed to Step 2.

State Criterion Template

State: _____

Evaluator: _____

Date: _____

Criterion Factors	Status	Rating (+ 0 -)	General comment/contacts
1. History of the issue past/current state/local efforts (bills introduced, surveys conducted, testimony prepared)			
2. Level of support or opposition from key decision makers			
• **STATE LEVEL** • Governor • Legislators, staff • Medicaid agency • State education agency			
• **LOCAL LEVEL** • Local education agency/ Medicaid billing agents • School administrators • Other related providers			
3. Paid lobbying • **Communication system – grassroots efforts**			
4. State association involvement • **Active SEAL** • **Medicaid/reimbursement committee**			
5. Political climate • **Leglislative calendar** • **Budgetary concerns**			
6. Notes			

State Action Plan Template

Date _____

State _____

Issue _____

Major Goals:

-
-
-
-

Activity Step	Activity Status	Person/s	Activity Completed
I. Legislative or Regulatory Activities • • • •			
II. Key Decision Makers a. Decision Maker Activity b. Decision Maker Activity c. Decision Maker Activity			
III. Grassroots Subplan Subplan Subplan			
Meeting/Convention Activities			
Oral or Written Presentation			
Training Activities			
Other			

Step 2: Developing a State Action Plan

A key component of a successful state advocacy program is an organized plan or strategy. In order to get started, your state association will need to identify an individual to chair or coordinate the campaign and a group of members to work with the coordinator or chair.

The state criterion template on page 20 identifies action areas that need to be addressed to achieve your state's desired goal. Once those action areas are identified, a long-range plan needs to be developed to organize the effort. A sample state action plan can be found on page 21. The plan divides advocacy areas into components and includes activity areas, activity status timelines, and persons responsible for completing the tasks or activities.

State associations have indicated that taking the time to develop a plan is crucial to a successful advocacy campaign. The state action plan has also helped state associations to examine their infrastructure and look at their issue in broader terms.

Your state association will need to determine and list your major goals and decide which components of the state action plan pertain to your effort. For example, if your effort requires the passage of legislation, your plan will contain legislative activities. Your plan may also need to contain a regulatory component. The components in each state action plan will vary depending on the goals of the effort. An important factor for any plan to consider is the time frame. Your state association must set a realistic time frame to achieve its goal; an effective state action plan will take at a minimum 2 to 3 years. We suggest periodically monitoring and revising your plan as needed.

State Action Plan Components

Legislative or regulatory activities

These activities pertain to the legislative or regulatory process in your state. They include activities such as:

- Determining your state's legislative or regulatory process
- Learning the time frame for your legislative calendar
- Reviewing the process for introducing a bill or regulation

- Identifying the key leaders with jurisdiction for your bill or state regulation
- Identifying potential supporters and opponents
- Studying the funding mechanisms that can support your effort
- Examining the language of a current bill, regulation, or guideline
- Crafting language to introduce a bill to regulation or to modify an existing bill or regulation

Key decision maker activities

These activities relate to identifying and meeting with the individuals or groups of individuals in your state who can influence the outcome of your effort. It is important to determine your supporters as well as your opposition. Your state action plan should identify these groups and develop strategies for working with both your supporters and those who may not agree with your goal. You will also need to consider whether your strategy will be to gain support from a group or to work to maintain the group's neutrality. It is also important to work with the staff or legislative aides of the various decision makers. Key staff or aides can be very knowledgeable and influential in gaining entry to a key policy maker. Key decision maker groups *may* include:

- Legislators
- Governors
- State Medicaid agency
- State education agency
- Local education agency/local Medicaid billing agents
- School administrators/superintendents

Grassroots activities

These activities involve organizing constituents in your state to contact key groups or individuals that can help achieve your public policy goal. Mobilizing the grassroots community is vital for any successful advocacy campaign. Grassroots involvement encourages increased communication and visibility for your effort and facilitates shared ownership of your goals. It is important that your state

association is organized and responsive to your members' concerns, and that your association advocates on behalf of its members. However, it is even more crucial that decision makers hear from their constituents about the issue.

Decision makers are influenced by the people who vote for them and who can vote them out of office. Grassroots advocacy consultant Joel Blackwell states that legislators want the approval of the people who put them in office. The voters are the legislators' customers and if they don't listen to their constituents, they will be out of business. Blackwell, in his book *Personal Power*, states that in any given election, only 20%–40% of all Americans vote, and even less than that ever make meaningful contact with their elected officials. Those people who take the time to make a visit or phone call, send a letter, or make a donation of time and/or money are the political elite who drive public policy. There are a variety of strategies that members can use to advocate for your issue:

- Contact key decision makers through visits, phone calls, letters, faxes, and e-mails
- Organize a letter-writing campaign, lobby day, or lobby breakfast
- Provide testimony at public legislative, regulatory, or budget hearings
- Attend key policy maker meetings
- Join an advocacy committee established for the effort
- Raise funds for your political action committee (PAC)
- Campaign for a key elected official
- Volunteer to work on a legislator's campaign

Subplans

Your state association may wish to divide the grassroots activities into subplans to involve any appropriate groups. Setting up an effective grassroots advocacy network to mobilize members is an essential component to any grassroots advocacy effort. Additional information about establishing a grassroots network will be addressed in Step 4.

Meetings/convention activities with colleagues or related professionals

These activities pertain to representing your issue at meetings or events that are related to your issue. Your state association's involvement in meetings and events provides increased visibility for your issue and demonstrates your commitment. Attendance at pertinent functions provides your association with an opportunity to build relationships and form alliances with other groups and policy makers. Your association might consider joining a committee to support other related issues that will allow you to get to know that group and its position on various issues. Eventually you may be able to request its support in return. We suggest brainstorming about possible policy maker meetings to attend that are directly related to your issue, such as hearings or committee meetings in which your issue will be debated or discussed or any meeting that might have an impact on your issue, such as a budget hearing.

Your state association may also consider joining a coalition of other related groups with similar interests or goals to strengthen your position. Strategy meetings with decision makers who support your issue can be very helpful in guiding your approach to your issue. Even arranging meetings with individuals or groups that are opposed to your issue can be helpful as a means to educate those individuals or groups about your issue, to learn about their concerns or viewpoints, or to negotiate a more neutral position.

Your advocacy committee should have a presence at your state convention and take advantage of any other regional meetings. State conventions and regional meetings are great forums to inform and update your members about the issue and your progress on the effort. They can also be ideal venues for recruiting additional volunteers or for conducting grassroots activities. Possible meeting or convention activities include:

- Attending budget or other related Medicaid hearings
- Attending board of education or school board meetings
- Attending state, regional, or local conventions or workshops
- Participating in state Medicaid agency or state or local education agency committees or other state-wide task forces
- Attending PAC fund-raisers for key legislators

Oral or written information/presentations

Prepare materials, testimony, or presentations to highlight the major points of your issue and provide supporting data. Your state action plan should consider any appropriate opportunities to present your position. Oral or written statements allow you to go on record with your views and proposals. There are circumstances when oral or written testimony is needed and should be prepared. Testimony or written statements are sometimes required for hearings or public comment periods. At other times, you may need or choose to submit a letter or prepare talking points that highlight your major points for legislator or policy maker visits.

Prepared materials should be short, concise, and include relevant data and supporting information. PowerPoint presentations are an effective means of carrying your message to decision makers and members at meetings or conventions.

Suggested written or oral communication activities include:

- Testimony
- Executive summary of testimony (1–2 pages)
- Talking points (1–2 pages)
- Letter requesting support
- PowerPoint presentations

Training activities

A comprehensive state plan should include a half-day or one-day training opportunity detailing the elements of grassroots advocacy training for the advocacy committee members in your state. Grassroots advocacy is an area that requires concentrated targeting. Some state associations may not be familiar with the legislative or regulatory process in their state and may not be comfortable with the term "grassroots advocacy" and what it entails. Additional information about establishing a grassroots network will be addressed in Step 4.

The following components are important in grassroots training:

- Explaining the importance of grassroots advocacy
- Understanding the legislative/regulatory process in your state

- Identifying individuals who can influence policy makers
- Determining your priorities/strategy
- Establishing a state plan
- Examining the role of the lobbyist
- Establishing an advocacy group/committee
- Recruiting and motivating members to lobby
- Establishing a database (phone tree, e-mail network)
- Establishing an effective communication system
- Identifying contacts/decision makers (legislators, state Medicaid agency representatives, state education agency representatives)
- Matching grassroots advocates (constituents) with key decision makers
- Developing the message/talking points for key contacts
- Activating the grassroots network
- Delivering the message
- Making visits and other contacts
- Sustaining the effort

Other Activities

There may be additional activities specific to your issue that you may wish to include in your state action plan. Take the time to analyze other areas that may need to be addressed and include the specific action steps needed in the pertinent areas on your state action plan.

Step 3: Developing Roles for Advocacy Partners

The state association, lobbyist, constituent members in your state, and ASHA all have essential and integral roles to play in any state advocacy effort. All parties need to collaborate and work together to achieve your goal. Misconceptions about how much influence a particular group actually has or reliance on any one group can lead to an ineffective effort. For example, a good lobbyist is critical to a state-wide initiative. However, the lobbyist

needs the grassroots support from the state association and its members to demonstrate to the policy makers how vital the issue is to the constituents in the state. Each party contributes important information and expertise and understands the issue from a unique perspective. All partners need to share information and contribute to the campaign in order for it to be successful.

State Association

The state association needs to survey its members to determine their priorities and confirm that a state advocacy effort to expand Medicaid coverage and reimbursement is a priority for its members. The volunteer leadership at the state level has knowledge of state issues and understands the state association's process for working for policy change. The state association needs to support the efforts with financial and personnel resources and recruit volunteers to work on this issue. It can contribute valuable state data and other state resources and provide a mechanism for promoting the effort at the state convention, and through its Web site and other communication vehicles. Your association can also promote member advocacy for this effort through the Take Action section of ASHA's Web site. The state association as a group can exercise a powerful voice because it represents a large group of individuals with concerns on expanding Medicaid coverage and reimbursement of speech-language pathology and audiology services.

Advocacy Committee

The advocacy committee is an essential player in the effort. The advocacy committee completes many of the specific tasks needed to sustain the effort. Usually, a committee of five to six individuals makes up an effective core advocacy committee. In addition to the core committee members, it is also necessary to recruit a group of members to participate in grassroots activities. The size and configuration of your advocacy committee will vary depending on the size of your state and your needs. Within the core advocacy committee, roles are further defined. A successful state campaign must have a strong coordinator/chair who is willing and able to devote the time, energy, and commitment needed to sustain an effort. Ideally the coordinator is someone experienced with the state association and state policy and knowledgeable about expanding Medicaid coverage and reimbursement. Another important

committee member is the grassroots coordinator, who works closely with the coordinator/chair to organize the grassroots activities. The grassroots coordinator should have experience with state legislative and regulatory issues and have the ability to respond to time-sensitive deadlines.

Constituent Members

Constituent members are individuals who reside in the legislator's or policy maker's district or who have a vested interest in the outcome of your efforts. Constituents participate in grassroots activities such as contacting legislators or policy makers through visits, letters, phone calls, faxes or e-mails; attending and testifying at hearings or other meetings; or extending invitations for visits to the site where they practice. Policy makers need to hear from individual constituents as well as from the state association because elected representatives need to be responsive to the people they are elected to represent. There is power in numbers when policy makers hear from a large number of individual constituents. When policy makers know that there is an issue that concerns many of their constituents, they will be more responsive to the issue.

Lobbyist

The lobbyist has the skills needed to advocate for your issue with legislators and policy makers and is familiar with your state politics and legislative/regulatory process. Your lobbyist tracks bills and regulations on a daily basis and knows many of the key players who can have an impact on your effort. Your lobbyist can be instrumental in determining the timing and strategy of your effort. For example, you may need to compromise to reach your goal, and your lobbyist can provide sound advice on whether to accept or reject the compromise position.

ASHA National Office

The ASHA National Office can offer the "big picture." ASHA can be an important resource for national data and can provide the national perspective about your state's issue. The ASHA Web site at **www.asha.org** has information about federal legislation and regulations that may impact your state effort. Through the Take Action portion of the ASHA Web site, your association can post a

synopsis of its issue, along with a sample letter, and direct members to contact their state legislator or regulator using the template provided. Members can also personalize their letters. ASHA can also serve as a financial resource through its grants and loan programs.

Step 4: Launching a Grassroots Campaign —There is Power in Numbers

One of the major components of your state action plan is grassroots activities. Your state initiative will benefit greatly if your state association formulates a focused grassroots advocacy plan and develops an organized grassroots network. Your state association and lobbyist have vital roles to play in advocating for your issue, but it cannot be emphasized enough that policy makers must hear from their constituents—the people who will be directly impacted by the issue.

Constituents should include parents or other consumers whenever appropriate and possible. Your advocacy committee will need to motivate and mobilize your members to participate in your grassroots efforts and encourage members to make contacts with your policy makers. Research conducted by grassroots consultant Joel Blackwell indicates that the top two most powerful influences on members of the legislature are face-to-face conversations and an original letter from a constituent (Blackwell, 2001). Grassroots networks involve organizing your member database, matching members with key legislators or policy makers, developing a communication system to mobilize members quickly into action, and producing advocacy materials for members to use when they are contacting key decision makers. ASHA has several resources on its Web site that provide good tips for making visits, writing letters, or testifying before your legislators. Go to the ASHA Web site at: **http://www.asha.org/about/legislation-advocacy/grassroots/takeaction.htm**

Creating a Database

A good place to start your grassroots network is by organizing your state association's database. Your state association needs to determine a system for maintaining a current member list. Member lists need to be updated once or twice each year to correspond with

your association's membership recruiting efforts. All available contact information, including e-mail addresses, should be requested for your membership database. Keeping membership lists current is not always routinely accomplished, making it more difficult to reach members. ASHA certified members in your state can also be accessed through the ASHA membership database.

Establishing Key Contacts

Once your state association membership list is current, you can match your constituent members with the key legislators or policy makers you have identified for your effort. Software programs are available that can match members by their legislative districts. Your lobbyist should be able to assist your state association in deciding whether to purchase a software package. Another technique is to use the state's legislative Web site to match members to their legislators. Once members are matched with key decision makers, your grassroots advocacy committee coordinator can target action alerts or other updates to those members.

Getting the Word Out

Communicate with your constituent members and general membership and encourage them to become involved in your effort. Once your association has a reliable and current database and key members are identified for your campaign, your grassroots coordinator can communicate with your members using an e-mail listserv or telephone tree. Short, concise, targeted action alerts or general updates can be e-mailed stating the issue, action needed, relevant deadlines, and method for reporting outcomes. The message or action needed can also be reinforced on your state association Web site and/or in the association's newsletter. E-mail blasts to ASHA members of your state association can also be coordinated through ASHA.

Making Legislator/Policy Maker Visits

Research has demonstrated that to successfully motivate policy makers to make a change, it is necessary to convince them that a lot of people in their districts care about the issue and they care a lot. The most powerful way to accomplish your goal is to have your members speak directly to the policy makers you are trying to

influence. This can be difficult to accomplish because people often feel uneasy or anxious visiting legislators or policy makers. Providing your members with grassroots training about how to make visits, and how to deliver a message effectively, can make their contacts go smoothly. Suggesting that they partner with other speech-language pathologists, parents, or other supporters when making visits can also alleviate their stress. Some common do's and don'ts for visits are:

Do's	**Don'ts**
• Be positive. • Be accurate. • Be brief. • Be polite. • Practice your message. • Learn about the policy maker's background and position. • Make a specific request (e.g., ask for support, cosponsor a bill). • Follow up with any questions that you cannot answer. • Write a thank you note. • Inform your committee of the results of the meeting.	• Be confrontational. • Get off message. • Use jargon. • Overstay your welcome.

Developing Talking Points and Legislative Packets

Prepare user-friendly information for your members for visits with policy makers. Develop talking points that are 1 to 2 pages long and include pertinent facts about your issue; describe the impact of the issue on your services, students, clients, and professionals; and if possible include real stories that will help to dramatize the issue and bring it to a more personal level. Legislative packets can be provided that identify your state association and issue and contain

talking points, brochures, or other relevant information. If possible, all members should use the same information and packets for your contacts. This will help your effort to appear organized and professional and will ensure that a consistent message is delivered to policy makers.

Other Grassroots Efforts

Other grassroots networking efforts can also be influential and effective. These include telephone calls, form letters, e-mails, faxes, rally or lobby days, testifying at public hearings or budget meetings, attending key policy maker meetings, hosting site visits at your school or facility, and contributing to or attending Political Action Committee (PAC) fund-raising activities for elected officials. Although visits or personal letters are often the most effective with legislators, elected officials can be impressed or influenced when they receive a large response or volume of messages about an issue. State associations can also use a combination of methods to get members involved. For example, conduct a letter writing campaign during the association's state convention using form letters, but also allow space for members to add their personal messages.

Step 5: Avoiding the Pitfalls

A successful advocacy effort requires certain key ingredients including support from the state association, a careful analysis of factors affecting state change, a state plan of action, a coordinator and committee willing to dedicate time and effort to the issue, grassroots support, and an effective communication system.

Effecting change at the state level requires persistence and patience. A state association must establish realistic goals and a time frame for achieving them. A legislative or regulatory victory typically requires, at a minimum, a 2 to 3-year campaign. The wheels of change turn slowly, particularly during a challenging budget climate, but change can occur if a state association is willing to maintain focus, establish priorities, and devote resources to the effort.

The first year should be devoted to educating your committee members, state association leaders and members, your lobbyist, and key decision makers about the issue. In the subsequent year, efforts should focus on establishing key relationships, building credibility

and visibility, and demonstrating your commitment to the issue. It is easy to bow out during tough times, but key decision makers need to see that your association is determined to stay the course and that you are serious about securing your goal.

Another key factor for success is a cadre of committed volunteers. Your issue will require time, commitment, and work. You must have a core group of volunteers willing to lead the charge. Along with a group of core volunteers, you need member constituents who will make their needs and concerns known to decision makers.

Communication is also important for success. By keeping members informed of your progress along the way, you will be more successful at sustaining current volunteers and recruiting new ones. Take the time to celebrate your achievements, no matter how small, because this will help motivate your volunteers and provide acknowledgement of your committee's hard work.

When your state association engages in an advocacy effort, it is inevitable that there will be some decision making or actions taken that, in hindsight, you would have done differently. There will be a natural learning curve through the process as there is with any long-term project or goal.

One common pitfall to avoid is unclear state association priorities. Remember, state association leadership and members must reach consensus as to what issues to tackle and prioritize those issues. Resources and volunteers are usually scarce so it is not realistic or practical to work on more than one or two issues at one time. Clearly publicize those priorities so that everyone is aware of the goals of the association. Members must be willing to work together for the common good of the profession.

Another obstacle to a successful advocacy campaign is lack of leadership by the chair of your advocacy committee. A committed and energetic chair is essential for a positive outcome.

Negative or delayed outcomes for your issue may also be a result of limited follow through and support by the association and its advocacy committee members. Once your priority has been established, it is critical to carry out your state action plan and engage your membership throughout the effort. Your state

association, committee members, and volunteers must be willing to sustain the effort and follow through on tasks when requests are made by the advocacy chair or the lobbyist. Volunteers need to realize that although there may be peak activity times, such as during a legislative session, an advocacy effort continues throughout the year.

Section Three

Sample Advocacy Tools

This section provides you with sample tools to use in your advocacy efforts and includes the following:

- Appendix A: State Medicaid audiology and speech-language pathology reimbursement rates
- Appendix B: National Fee Data/Medicare Fee Averages
- Appendix C: ASHA's "Dollar a Day" Brochure

Information available on ASHA's Web site:

http://www.asha.org/about/Legislation-Advocacy/state/

1. State Policy - ASHA's state policy site provides information on state licensure, state insurance mandates for hearing aids, early hearing detection and intervention, and provides model bills for the following:
   a. Mandated Health Benefits for Audiology and Speech-Language Pathology Services;
   b. Mandated Offering of Health Benefits for Audiology and Speech-Language Pathology Services;
   c. Insurance Coverage of Hearing Aids for Children
2. Treatment Efficacy Summaries: http://www.asha.org/members/issues/reimbursement/
3. Information on infant hearing screening legislation (EHDI): http://www.asha.org/about/legislation-advocacy/state/issues/overview.htm

STATE*	AUDIOLOGY CPT CODES 92510 - 92543							
	92510	92531	92532	92533	92534	92541	92542	92543
Alaska	$ 175.70	--	$ 63.75	--	--	$ 75.31	$ 76.10	$ 36.87
Arizona	--	--	--	--	--	--	--	--
California	$ 124.11	--	--	$ 35.34	--	$ 18.48	$ 17.67	$ 15.60
Florida	$ 70.89	--	--	--	--	$ 36.51	$ 33.81	$ 9.86
Georgia	$ 97.27	--	--	--	--	--	--	--
Hawaii	$ 88.44	--	$ 22.00	$ 28.00	--	$ 29.68	$ 26.59	$ 9.37
Idaho	$ 120.55	$ 31.31	$ 48.32	$ 10.89	$ 31.31	$ 60.86	$ 56.34	$ 16.27
Illinois	$ 49.30	--	--	--	--	--	$ 22.15	$ 22.15
Indiana	$ 120.28	--	--	--	--	--	--	--
Kentucky	$ 84.14	$ 6.96	$ 5.83	$ 6.69	$ 2.76	$ 31.41	$ 27.75	$ 35.33
Louisiana	--	--	--	--	--	--	--	--
Maine	27.74 p/1/2hr	--	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--	--	--
Michigan	--	--	--	--	--	--	--	--
Minnesota	--	--	$ 16.80	$ 24.11	--	$ 47.15	$ 47.15	$ 94.68
Mississippi	--	--	--	--	--	--	--	--
Montana	--	--	--	--	--	--	--	--
Nebraska	$ 87.72	--	--	--	--	--	--	--
Oklahoma	$ 86.29	--	--	--	--	$ 32.75	$ 33.16	$ 15.34
Pennsylvania	--	--	--	--	--	$ 25.40	$ 35.04	$ 43.02
South Carolina	$ 78.45	--	--	--	--	$ 25.06	$ 22.07	$ 29.02
South Dakota	--	--	--	--	--	--	--	--
Utah	$ 74.17	$ 12.43	$ 14.35	$ 22.97	$ 10.28	$ 6.21	$ 6.93	$ 5.86
Washington	$ 83.27	--	--	--	--	$ 35.26	$ 35.49	$ 17.06
West Virginia	$ 99.13	--	--	--	--	--	--	--
Wisconsin	$ 75.95	$ 57.53	$ 37.12	$ 24.22	$ 42.06	$ 34.67	$ 30.70	$ 39.29

* Information was not available for the following states: Alabama, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Iowa, Kansas, Maryland, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Wyoming.

STATE*	AUDIOLOGY CPT CODES 92544 - 92555								
	92544	92545	92546	92547	92548	92551	92552	92553	92555
Alaska	$ 61.51	$ 56.68	$ 126.49	$ 69.21	$ 227.15	$ 21.25	$ 23.93	$ 35.40	$ 20.45
Arizona	--	--	--	--	--	--	--	--	--
California	$ 17.67	$ 17.67	$ 17.67	$ 17.67	--	$ 12.67	$ 19.00	$ 25.34	$ 13.91
Florida	$ 31.68	$ 30.52	$ 49.07	$ 24.34	--	--	$ 8.69	$ 12.94	$ 7.53
Georgia	--	--	--	--	--	$ 14.49	$ 15.62	--	$ 13.38
Hawaii	$ 21.00	$ 18.96	$ 23.36	$ 19.04	$ 75.05	$ 10.13	$ 15.10	$ 22.15	$ 12.92
Idaho	$ 52.63	$ 50.63	$ 81.42	$ 39.49	$ 86.73	$ 13.08	$ 13.93	$ 20.67	$ 12.02
Illinois	$ 22.15	$ 22.15	$ 22.15	$ 22.15	$ 39.35	$ 15.20	$ 15.20	$ 15.20	$ 15.20
Indiana	--	--	--	--	--	--	--	--	--
Kentucky	$ 21.45	$ 18.45	$ 23.94	$ 15.67	$ 66.72	$ 12.24	$ 12.24	$ 18.60	$ 10.63
Louisiana	--	--	--	--	--	$ 3.60	$ 22.50	$ 45.00	$ 9.00
Maine	--	--	--	--	--	$ 23.50	$ 30.00	$ 47.00	$ 30.00
Massachusetts	--	--	--	--	--		$ 13.01	$ 17.02	$ 10.18
Michigan	--	--	--	--	--	$ 19.13	$ 19.77	$ 19.77	$ 28.10
Minnesota	$ 47.15	$ 47.15	$ 94.68	$ 47.15	--	$ 8.91	$ 24.33	$ 66.19	$ 24.33
Mississippi	--	--	--	--	--	--	--	--	--
Montana	--	--	--	--	--	--	--	--	--
Nebraska	--	--	--	--	--	$ 12.04	$ 12.04	$ 17.20	$ 8.60
Oklahoma	$ 26.36	$ 24.45	$ 49.32	$ 27.43	$ 88.20	$ 17.58	$ 10.50	$ 15.53	$ 9.13
Pennsylvania	$ 17.61	$ 19.48	$ 18.30	$ 19.90		$ 8.00	$ 8.00	$ 14.00	$ 6.50
South Carolina	$ 17.53	$ 15.23	$ 28.22	$ 35.24	$ 54.58	$ 9.02	$ 10.77	$ 15.02	$ 8.58
South Dakota	--	--	--	--	--	--	--	--	--
Utah	$ 7.74	$ 7.74	$ 6.46	$ 23.70	$ 39.00	$ 6.93	$ 11.72	$ 17.46	$ 10.04
Washington	$ 28.66	$ 26.39	$ 58.92	$ 31.62		$ 10.18	$ 10.92	$ 16.15	$ 9.33
West Virginia	--	--	--	--	--	--	--	--	--
Wisconsin	$ 23.77	$ 20.46	$ 26.42	$ 18.86	$ 77.91	$ 12.56	$ 16.41	$ 23.11	$ 14.51

STATE*	AUDIOLOGY CPT CODES 92556 - 92586								
	92556	92557	92567	92568	92569	92579	92582	92585	92586
Alaska	$ 30.93	$ 63.85	$ 28.44	$ 20.45	$ 21.94	$ 38.88	$ 38.88	$ 132.23	$ 97.69
Arizona	--	--	--	$ 15.49	$ 23.83	$ 48.79	--	--	--
California	$ 33.53	$ 51.82	--	$ 11.77	$ 12.69	$ 32.25	--	--	$ 84.32
Florida	$ 11.39	$ 23.76	$ 10.63	$ 7.53	$ 8.12	$ 14.30	$ 14.30	$ 50.61	--
Georgia	--	$ 42.04	$ 18.46	$ 13.38	--	$ 25.19	$ 25.19	$ 109.76	$ 60.23
Hawaii	$ 19.35	$ 40.56	$ 17.78	$ 12.92	$ 13.85	$ 24.34	$ 24.34	$ 102.83	$ 53.88
Idaho	$ 18.12	$ 37.84	$ 16.85	$ 12.02	$ 12.98	$ 22.90	$ 22.90	$ 83.04	$ 57.97
Illinois	$ 15.20	$ 37.40	$ 15.20	$ 15.20	$ 15.20	$ 22.15	$ 22.15	$ 53.75	$ 47.80
Indiana	--	--	--	--	--	--	--	--	--
Kentucky	$ 15.94	$ 33.47	$ 14.87	$ 10.63	$ 11.43	$ 20.21	$ 20.21	$ 109.38	$ 50.49
Louisiana	$ 22.50	$ 54.00	$ 22.50	$ 22.50	$ 36.00	--	$ 45.00	$ 180.00	--
Maine	$ 47.00	$ 94.00	$ 40.00	$ 31.00	$ 23.50	--	--	--	--
Massachusetts	$ 15.79	$ 43.00	$ 17.22	$ 12.39	$ 13.09	$ 14.93	$ 14.93	$ 71.70	$ 52.34
Michigan	$ 28.80	$ 29.16	$ 12.79	$ 9.20	$ 9.87	$ 19.13	$ 19.13	$ 208.00	$ 36.10
Minnesota	$ 24.33	$ 66.19	$ 24.33	$ 24.33	$ 24.33	--	$ 66.19	$ 155.69	$ 62.22
Mississippi	--	--	--	--	--	--	--	--	--
Montana	--	--	--	--	--	--	$ 67.00	--	--
Nebraska	$ 17.20	$ 37.84	$ 11.55	$ 6.88	$ 6.88	$ 24.08	$ 10.32	$ 103.20	$ 92.88
Oklahoma	$ 13.70	$ 28.31	$ 12.55	$ 9.13	$ 9.82	$ 16.90	$ 16.90	$ 61.53	$ 43.63
Pennsylvania	$ 15.00	$ 29.00	$ 12.00	$ 9.50	$ 24.50	--	--	$ 26.50	$ 66.19
South Carolina	$ 11.99	$ 26.39	$ 11.58	$ 7.76	$ 8.32	$ 16.55	$ 26.94	$ 88.83	$ 48.09
South Dakota	--	--	--	--	--	--	--	--	--
Utah	$ 15.31	$ 31.82	$ 14.11	--	$ 10.76	$ 18.58	$ 19.14	$ 154.00	$ 45.53
Washington	$ 14.11	$ 28.89	$ 12.97	$ 9.33	$ 10.01	$ 17.75	$ 17.75	$ 61.20	$ 44.36
West Virginia	--	--	--	--	--	--	--	--	--
Wisconsin	$ 21.34	$ 38.18	$ 17.03	$ 12.94	$ 14.64	$ 25.29	$ 15.07	$ 151.03	--

STATE*	AUDIOLOGY CPT CODES 92587 - 92604							
	92587	92588	92590	92591	92601	92602	92603	92604
Alaska	$ 79.16	$ 103.50	$ 80.00	$ 150.00	$ 177.10	$ 124.41	$ 119.43	$ 81.65
Arizona	--	--	--	--	--	--	--	--
California	$ 50.92	$ 65.01	$ 43.58	$ 43.58	$ 114.93	$ 80.56	$ 77.32	$ 52.68
Florida	$ 29.75	$ 39.79	--	--	--	--	--	--
Georgia	$ 52.52	$ 70.52	--	--	--	--	--	--
Hawaii	$ 50.22	$ 66.75	$ 82.87	$ 84.00	$ 105.52	$ 73.97	$ 70.98	$ 48.36
Idaho	$ 48.08	$ 65.06	$ 43.53	$ 87.05	--	--	--	--
Illinois	$ 52.70	$ 61.00	$ 37.40	$ 37.40	$ 55.01	$ 38.72	$ 37.18	$ 25.49
Indiana	--	--	--	--	--	--	--	--
Kentucky	$ 43.18	$ 60.05	$ 45.00	$ 165.00	$ 91.49	$ 64.26	$ 61.69	$ 42.16
Louisiana	--	--	$ 65.00	$ 65.00	--	--	--	--
Maine	$ 47.00	$ 70.00	--	--	--	--	--	--
Massachusetts	$ 49.15	$ 68.78	$ 16.92	$ 25.10	--	--	--	--
Michigan	$ 35.89	$ 51.91	$ 50.98	$ 50.95	$ 79.85	$ 56.07	$ 53.83	$ 36.78
Minnesota	$ 47.15	$ 47.15	$ 43.85	$ 65.04	$ 24.33	--	--	--
Mississippi	--	--	$ 33.26	--	--	--	--	--
Montana	--	--	--	--	--	--	--	--
Nebraska	$ 41.28	$ 60.20	$ 37.84	$ 56.26	--	--	--	--
Oklahoma	$ 35.71	$ 47.93	$ -	$ 49.87	$ 79.96	$ 55.46	$ 52.49	$ 34.86
Pennsylvania	$ 49.22	$ 68.23	$ 18.00	$ 18.00	--	--	--	--
South Carolina	$ 35.23	$ 49.22	$ 46.55	$ 46.55	$ 81.40	$ 56.83	$ 54.54	$ 36.93
South Dakota	--	--	--	--	--	--	--	--
Utah	$ 33.45	$ 37.86	$ 26.79	$ 40.19	$ 109.51	$ 76.72	$ 73.63	$ 50.13
Washington	$ 36.17	$ 47.77	--	--	$ 81.67	$ 57.10	$ 54.83	$ 37.31
West Virginia	--	--	--	--	--	--	--	--
Wisconsin	$ 49.53	$ 68.33	--	--	--	--	--	--

STATE*	Speech-Language Pathology CPT CODES 92506 - 92609								
	92506	92507	92526	92597	92605	92606	92607	92608	92609
Alaska	$121.91	$102.05	$106.39	$121.91	$147.73	$80.01	$147.73	$29.42	$80.10
Arizona	--	--	--	--	--	--	$107.05	$21.42	$58.07
California	$44.06	$37.69	$42.89	$103.86	$44.09	$34.76	$121.72	$18.80	$51.95
Florida	$48.50	16.97 p/unit	--	$97.50	--	--	$97.50	--	--
Georgia	$54.00	$40.99	$46.13	$85.57	--	--	--	--	$52.97
Hawaii	$34.29	$21.05	$22.46	$49.72	--	--	$88.11	$17.26	$47.70
Idaho	$85.46	$67.54	$68.90	$92.22	--	--	--	--	--
Illinois	$37.40	$19.85	$0.00	--	$24.90	$24.90	$45.85	$9.25	$24.90
Iowa	$85.26	$67.32	$68.68	--	--	--	--	--	--
Kentucky	$40.40	$24.84	$29.08	$62.33	--	--	$76.32	$15.17	$41.38
Louisiana	$45.00	30.00 p/1 hr	--	--	--	--	--	--	--
Maine	27.74 p 1/2hr	27.74 p 1/2hr	--	$13.87	--	--	--	--	--
Massachusetts	$41.51	$10.38	$10.38	--	--	--	--	--	--
Michigan	$50.98	$35.95	$45.31	$64.83	--	--	$66.61	$13.23	$36.11
Minnesota	$24.51	$12.43	$15.21	$17.06	--	--	--	--	--
Montana	--	$45.00	--	--	--	--	--	--	--
Nebraska	$50.56	$30.96	--	$72.24	--	--	--	--	--
Nevada	5.37 p/unit	5.37 p/unit	--	--	--	--	--	--	--
Ohio	$62.16	$38.18	--	--	--	--	$62.16	--	--
Oklahoma	$82.95	$39.69	$52.58	--	--	$0.00	$74.93	$15.88	$37.51
Pennsylvania	$45.00	$21.70	--	--	--	--	--	--	--
South Carolina	$35.07	--	$24.29	--	--	--	$68.08	$12.95	$39.76
Utah	$75.00	$42.00	$28.57	$60.63	--	$0.00	$46.41	$20.00	$26.00
Virginia[a]	$115.32	$95.91	--	--	--	--	--	--	--
Washington	--	--	$50.05	$65.52	--	--	$68.02	$13.42	$36.86
West Virginia	$69.98	$54.67	$55.57	--	--	--	--	--	--
Wisconsin	$57.19	$45.18	$46.03	$71.61	--	--	$59.97	$29.99	$44.92
Wyoming[b]	$14.00	$14.00	--	--	--	--	--	--	--

[a] School divisions receive 50 percent of these rates

[b] XB Medicaid pays $14.00 per 15 minute unit

* Information was not available for the following states: Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Indiana, Kansas, Maryland, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Texas, and Vermont.

STATE*	Speech-Language Pathology CPT CODES 92610 - 97532								
	92610	92611	92612	92614	92616	96110	96111	96115	97532
Alaska	$57.31	--	--	--	$68.66	$121.38	--	--	$30.32
Arizona	--	--	--	--	--	--	--	--	--
California	$61.87	$50.67	--	--	$24.92	$67.87	$50.67	--	--
Florida	--	--	--	--	--	--	--	--	--
Georgia	$37.65	--	--	--	--	$43.06	$62.10	--	$20.43
Hawaii	$33.70	$36.68	$135.11	$103.26	$141.09	--	--	--	--
Idaho	--	--	--	--	$45.28	$26.52	$55.96	$55.96	--
Illinois	$18.00	$19.55	$30.25	$30.25	$44.00	--	--	--	--
Iowa	--	--	--	--	--	--	--	--	$20.88
Kentucky	$29.57	$32.14	$124.70	$97.21	$133.52	--	--	--	--
Louisiana	--	--	--	--	--	--	--	--	--
Maine	--	--	--	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--	--	--	--
Michigan	$25.79	--	--	--	--	--	--	$42.62	$15.26
Minnesota	$59.11	--	--	--	--	--	--	--	--
Montana	--	--	--	--	--	--	--	--	--
Nebraska	--	--	--	--	--	--	--	--	--
Nevada	--	--	--	--	--	--	--	--	--
Ohio	--	--	--	--	--	--	--	--	--
Oklahoma	$78.69	$78.69	--	$88.36	$123.93	--	--	--	--
Pennsylvania	--	--	--	--	--	--	--	--	--
South Carolina	$25.46	$27.75	$109.89	$85.10	$117.22	--	--	--	--
Utah	$34.87	$37.97	$146.12	--	--	--	--	--	--
Virginia[a]	--	--	--	--	--	--	--	--	--
Washington	$26.16	$28.44	$107.15	$82.58	$113.07	--	--	--	--
West Virginia	--	--	--	--	--	--	--	--	$17.12
Wisconsin	$68.10	--	--	--	--	--	--	--	$17.19
Wyoming[b]	--	--	--	--	--	--	--	--	--

Table 1. National Fee Data/Medicare Fee Averages

This section provides fee information obtained from the Medicare Fee Schedule (MFS) and the 2003 Milliman USA report on speech-language pathology and audiology services. The data reflect the average cost per service by CPT code. Use the information to help you evaluate how your fees compare nationwide. Remember that the Milliman data are not to be shared with entities beyond ASHA members. Nevertheless, these data can be used as a reference for negotiating rates.

Establishing fees for procedures takes care. Fees that are too high will lead to disputes with patients and payers, and fees that are too low will result in inadequate reimbursement. Finding a balance between these two extremes is your goal.

A special caveat: In determining fees for your services avoid any method that can be construed as price-fixing, such as discussing fees with other local practices. Setting prices in collusion with colleagues is illegal.

CPT	Description	Average Cost Per Service (Milliman USA)	Medicare Average 2004
31575	Laryngoscopy, flexible fiberoptic; diagnostic	$452.80	$115.00
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	761.29	233.36
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	152.71	131.43
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	117.66	62.35
92508	group, two or more individuals	100.63	29.50
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming	249.96	136.28
92511	Nasopharyngoscopy with endoscope (separate procedure)	135.10	150.10
92512	Nasal function studies (e.g., rhinomanometry)	0.00	57.77
92516	Facial nerve function studies (e.g., electroneuronography)	58.39	50.03
92520	Laryngeal function studies	81.15	48.54
92526	Treatment of swallowing dysfunction and/or oral function for feeding	83.76	83.26

CPT	Description	Average Cost Per Service (Milliman USA)	Medicare Average 2004
92531	Spontaneous nystagmus, including gaze (screen, without recording)	0.00	0.00
92532	Positional nystagmus test (screen, without recording)	0.00	0.00
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests) (screen, without recording)	0.00	0.00
92534	Optokinetic nystagmus test (screen, without recording)	0.00	0.00
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	122.89	52.65
-26		0.00	22.78
92542	Positional nystagmus test, minimum of 4 positions, with recording	100.28	53.02
-26		0.00	18.67
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	0.00	24.27
-26		0.00	5.97
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	114.74	42.19
-26		0.00	14.56
92545	Oscillating tracking test, with recording	112.96	39.20
-26		0.00	13.07
92546	Sinusoidal vertical axis rotational testing	61.12	79.16
-26		0.00	16.06
92547	Use of vertical electrodes (list separately in addition to code for primary procedure)	132.22	45.18
92548	Computerized dynamic posturography	132.01	143.38
92551	Screening test, pure tone, air only	29.65	0.00
92552	Pure tone audiometry (threshold); air only	31.64	17.92

CPT	Description	Average Cost Per Service (Milliman USA)	Medicare Average 2004
92553	air and bone	48.73	26.88
92555	Speech audiometry threshold;	24.90	15.31
92556	with speech recognition	43.25	23.52
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	86.04	48.91
92559	Audiometric testing of groups	27.17	0.00
92560	Bekesy audiometry; screening	27.06	0.00
92561	diagnostic	53.01	29.12
92562	Loudness balance test, alternate binaural or monaural	30.50	16.43
92563	Tone decay test	28.32	15.31
92564	Short increment sensitivity index (SISI)	35.58	19.42
92565	Stenger test, pure tone	60.33	16.06
92567	Tympanometry (impedance testing)	39.96	21.66
92568	Acoustic reflex testing	30.00	15.31
92569	Acoustic reflex decay test	34.91	16.43
92571	Filtered speech test	29.05	15.68
92572	Staggered spondaic word test	6.54	3.73
92573	Lombard test	27.59	14.56
92575	Sensorineural acuity level test	23.24	11.95
92576	Synthetic sentence identification test	33.40	18.30
92577	Stenger test, speech	72.20	29.50

CPT	Description	Average Cost Per Service (Milliman USA)	Medicare Average 2004
92579	Visual reinforcement audiometry (VRA)	49.65	29.50
92582	Conditioning play audiometry	49.49	29.50
92583	Select picture audiometry	66.08	36.22
92584	Electrocochleography	181.40	100.81
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	220.97	102.30
-26		63.25	27.63
92586	limited	205.85	74.67
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	111.33	60.86
92588	comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	96.98	79.90
92589	Central auditory function test(s) (specify)	40.67	22.03
92590	Hearing aid examination and selection; monaural	123.50	0.00
92591	binaural	121.78	0.00
92592	Hearing aid check; monaural	52.00	0.00
92593	binaural	69.18	0.00
92594	Electroacoustic evaluation for hearing aid; monaural	33.38	0.00
92595	binaural	65.52	0.00
92596	Ear protector attenuation measurements	44.30	24.27
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	0.00	97.08
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing) with interpretation and report, per hour	148.54	72.81
96110	Developmental testing; limited (Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	64.04	13.81

CPT	Description	Average Cost Per Service (Milliman USA)	Medicare Average 2004
96111	extended (includes assessment of motor, language, social, adaptive and/ or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour	47.53	143.75
96115	Neurobehavorial status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour	85.66	72.81
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	74.37	28.75
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities	62.71	28.75
97150	Therapeutic procedure(s), group (2 or more individuals)	42.74	17.55
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	67.68	29.12
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes	47.64	24.64
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	N/A	25.76
97535	Self-care/home management training (e.g. Activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by provider, each 15 minutes	N/A	30.24
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes	N/A	27.26

Source: Ingenix, Inc.

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American Speech-Language-Hearing Association

Section Four

Resources

National Office contacts:

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852
800-498-2071

Name	E-mail	Extension
Ingrida Lusis	ilusis@asha.org	4482
Eileen Crowe	ecrowe@asha.org	4221
Mark Kander	mkander@asha.org	4139

Web sites

American Speech-Language-Hearing Association
http://www.asha.org

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov