



New York State
Speech-Language-Hearing
Association, Inc.

NYPTA
New York Physical Therapy Association



New York State Benchmark Plan Recommendations

Introduction

The Patient Protection and Affordable Care Act (ACA) includes Rehabilitative and Habilitative Services and Devices as one of the ten categories to be covered by Essential Health Benefits. We are aware that States are still awaiting guidance from the Department of Health and Human Services (HHS) related to the definition of rehabilitative and habilitative services in order to determine what would constitute meaningful benefits under this category to be provided by the health plans in State exchanges.

The New York State Occupational Therapy Association, New York State Speech-Language-Hearing Association and New York Physical Therapy Association, with the assistance of our members providing these services, have developed the following recommendations for consideration by New York State policy makers related to defining both in term and benefit structure, rehabilitative and habilitative services and devices. Our Associations considered recommendations and practices of other state and federal bodies including the National Association of Insurance Commissioners, our national Associations, Medicare, the New York State Department of Financial Services and existing private health insurance plans in the State in the development of these recommendations. Our collective goal is to ensure that individuals with physical, intellectual, cognitive and developmental disabilities who will receive their health insurance coverage through New York's Health Exchange are able to access comprehensive services to enable them to function at the highest level possible for daily living based on their illness, injury or disability.

We appreciate your consideration of the recommendations set forth below. We look forward to continuing to work with you as you implement the Essential Health Benefits under New York's Health Exchange.

Definition of Rehabilitation and Habilitation

The subsequent definitions considered the NAIC recommendations to HHS based on their Consumer Information Subgroup, which we amended for purposes of clarification.

Rehabilitation Services

Rehabilitation refers to health care services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

[Adapted from Fed. Reg. 52530; NAIC Glossary of Health Insurance and Medical Terms: 3]

Maintenance Program within Rehabilitation

Planning a program and instructing a patient and/or caregiver on a program to promote retention of skills attained through rehabilitation services is an established cost-effective component to maximizing patient functioning. The implementation of a maintenance program can delay deterioration of skills in progressive neurological diseases, such as Multiple Sclerosis, Parkinson's disease or Amyotrophic Lateral Sclerosis [ALS/Lou Gehrig's disease], and non-progressing neurological disorders such as cerebral palsy traumatic brain injury and stroke.

Habilitation Services

Habilitation refers to health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitative services. Habilitative services include physical therapy, occupational therapy, speech-language pathology, audiology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing Benefits

To help avoid future claims for costly illnesses and/or injuries that are linked to untreated hearing disorders, we recommend that audiology services and devices be included in the habilitation and rehabilitation benefit of New York's Essential Health Benefits plan.

The practice of audiology includes the diagnosis, treatment and management of individuals with hearing loss or balance problems. Hearing enables people to socialize, work, interact, and communicate. The ability to hear helps assure safety within the environment. In addition, studies have shown that corrected hearing loss may potentially be of benefit in fighting the effects of dementia

Because the vestibular system is located in the inner ear, Audiologists are a crucial part of a team that diagnoses and treats balance and related disorders. Dizziness and balance problems are the third most frequent complaint that physicians receive from patients of all ages. Studies show that patients with just a mild, uncorrected hearing loss are three times more likely to fall than those with normal hearing. Additionally, patients of any age with vestibular problems are at risk for injury related to falls. Audiology, therefore can assist not only in improving communication of a patient with a hearing loss, but can also help to diagnosis and treat those at risk for injury due to falls.

Maintenance Therapy within Habilitation

Evidence shows that interventions enabling persons to maintain their function are high quality and cost-effective. Maintenance of function therapy can halt deterioration, help prevent harmful and costly secondary conditions, allow for independent living and greater participation in the community, all while limiting expensive inpatient admissions and readmissions, other costly care, and negative social effects. Maintenance therapy is particularly important for children and persons born with disabilities, populations who never possessed certain functional skills and must receive habilitative services to attain such skills and maintenance of function therapy to keep them. Each aspect of maintenance therapy also advances the ACA's aim to focus on preventive care and balance cost and coverage, and thus maintenance or retaining of function must be included in the EHB definition of "habilitative services."

Recommendations for Devices

The provision of appropriate treatment in habilitation and rehabilitation may require the use of devices in order for a patient to receive the full benefit of the therapy services and to maintain the function developed through these services.

Assistive devices, durable medical equipment, orthotics and prosthetics are designed or selected and utilized as part of a prevention, rehabilitation or habilitation program by occupational therapists and physical therapists. These devices are designed or selected to prevent deterioration in physical functioning or to enable improved functioning or mobility. Therapy may include training patients and care-givers in the use of devices to achieve prevention, rehabilitation or habilitation goals.

Communication devices assist and enable individuals with speech, hearing and language disorders to communicate when their speech or hearing does not develop due to a congenital disability or when it is lost due to illness or injury. Communication devices include Alternate and Augmentative Communication (AAC) devices, artificial voice devices (such as the electro larynx) and hearing aids, alternative listening devices, cochlear implant and associated components. As technology advances, many of these devices must be supported by relevant software.

Managing the Rehabilitation and Habilitation Benefit

Managing the rehabilitation benefit in a reasonable and effective manner will be essential to the success of the benchmark plan. At the same time, unreasonable limits or excessive cost sharing will defeat the ultimate purpose of the insurance plan, to make rehabilitation services accessible to patients.

First, the rehabilitation benefit can be managed by clearly defining and limiting the providers of rehabilitation services to the licensed qualified providers that are widely recognized as rehabilitation providers: occupational therapy, physical therapy and speech language pathology.

Provider networks should be adequate so that access to therapy services is reasonable. Adequate geographic distribution should be considered for people with disabilities who may have travel restrictions.

Limits

The ACA prohibits dollar and lifetime limits starting in 2014, but “scope and duration limits are allowed” In rehabilitation, flexibility in limits across occupational therapy, physical therapy, speech-language pathology, and audiology would allow for adaptation of the benefits package to different treatment needs in different diagnostic categories, while remaining within actuarial limits. Any limits to coverage of therapy that are imposed should be transparent to the beneficiary and providers. Treatment limits should be neither arbitrary, nor too restrictive, and should meet medical necessity standards. Group and individual plans with limits should allow for appeals. Medical review of therapy claims and appeals should be fair, straightforward and include consultation with peers in the same profession and an exceptions process that allows for continued therapy when documented progress and medical necessity are provided will make care available to those most in need.

Habilitation benefits for the purpose of attaining skills and functioning for communication and daily living will have a greater duration of medical necessity.

Co-payments

Therapy services may range widely in frequency and duration due to the diagnosis, co-morbidities and the extent of disability. However, for a patient with a disabling condition therapy sessions may be 2-3 times per week over multiple weeks. Co-payments for each session that are excessive will not achieve the desired goal of preventing over-utilization of services, but rather make access to medically necessary services financially infeasible for the patient.

Substitution

Substitution within the category will likely be allowed, however ACA requires that this has to be actuarially equivalent. Flexibility in benefits allows greater choice for consumers. In rehabilitation flexibility in limits between occupational therapy, physical therapy and speech pathology, allows for adaptation of the covered benefits to meet the different treatment needs in different diagnostic categories, while remaining within actuarial limits. Substitutions across categories seriously risks the elimination of essential benefits in other categories, or rendering those benefits ineffective and substitution within the category may leave the most medically involved

patients vulnerable; however, an exceptions process that allows for continued therapy when documented progress and medical necessity are provided will make care available to these individuals.

Non-Discrimination Provisions

The ACA requires an appropriate balance between the essential health benefit categories, including parity in the providing of all categories of benefits. Coverage decisions such as the design of benefits shall not discriminate against people with disabilities. The ACA, in fact requires that the health care needs of people with disabilities must be considered. In addition, the essential health benefits provided in a plan must not be subject to denial on the basis of the individual's present or predicted disability, degree of medical dependency or quality of life.

Medical Necessity

Collectively recipients and other populations with disabilities, participation restrictions, or those at risk for disability and in need of rehabilitation and habilitation services comprise a growing percentage of health care consumers. At the same time, the current definitions of medical necessity may fall far short of addressing the coverage needs for these populations.

A covered service or item is medically necessary if it will do, or is reasonably expected to do, one or more of the following:

- Arrive at a correct diagnosis
- Prevent the onset or deterioration of an illness, condition, injury, secondary conditions, co-morbidities, disability or participation restriction
- Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury, or disability
- Assist the individual to achieve sufficient functional capacity through rehabilitation or habilitation to perform appropriate daily activities and communicate effectively.
- Assist care-givers through training and support to achieve the aforementioned objectives

The determination of medical necessity should take into consideration information regarding health, functional performance and the individual's interaction with their environment, as provided by the following persons: the individual (as appropriate to his or her age and communicative abilities), the individual's family, the primary care physician, and consultants with appropriate specialty training, as well as other providers, programs, multidisciplinary teams, educational institutions, or agencies that have evaluated the individual.

The determination of medical necessity should be made on an individual basis and should consider:

- The functional capacity of the person and those capacities that are appropriate for persons of the same age or developmental level.
- The long term cost to the individual, the family and the community that may result from not providing such service or item.
- Available research findings regarding effectiveness, evidence-based practice, health care practice guidelines, and standards issued by professionally recognized organizations or government agencies.

The determination of medical necessity may include consideration of whether there is an equally effective and safe, but less costly, alternative to the recommended treatment.

Medically necessary services may be delivered in a setting (e.g., an individual's home, health care setting, school, child care center, workplace, or in the community) that is appropriate to the specific health, rehabilitation and habilitation needs of the individual.

Decisions regarding medical necessity should provide for

- Transparency with respect to standards and processes;
- Predictability;
- Fairness/equitability;
- Uniform application across geographic regions and similarly situated patients;
- Timely determination and appeals procedures that provide for the safety and welfare of the individual;
- Financially sustainable/economical/ fiscally responsible; and
- Consumer choice and responsibility.

The opportunity for an external appeal must be made available to all individuals or their representatives. Final determinations should be made by a physician in concert with the following persons: the individual's primary care physician; a consultant from the same profession and same or similar specialty as that under review and with experience appropriate to the individual's age, disability, or chronic condition; and the individual and/or family.

Exceptions/Appeals Process

Since Rehabilitation and Habilitation services are included as an Essential Health Benefit category under ACA, plans should have a fair and patient-centered exceptions or appeals process in place that allows individuals to receive these services beyond any cap or other limitations put in place by health insurance plans, when needed based upon medical necessity.

Plan exceptions or appeals processes should include both internal and external appeal processes.

Internal plan appeals processes should:

- Use an automatic process for receiving, considering and responding to appeal requests by individuals or their providers in a timely fashion. For many patients, delays in initiating or completing needed therapy can seriously jeopardize their life, health or ability to acquire, keep or improve functioning for daily living. If there are delays in the internal appeals process by health insurance plans and the ultimate decision is to deny the services, some patients will not make it to the State's external appeals process due to the severity of their illness, injury or disability. A user friendly, expedited appeals process must be in place to assist such individuals.
- Permit individuals to receive services beyond any caps or other limits based on medical necessity and expectation of reasonable progress.
- Provide that final decisions be made by a physician in concert with the individual's primary care physician; a consultant from the same profession and same or similar specialty as that under review and with professional experience appropriate to the individual's age, illness, injury or disability; and the individual and/or family.

External plan appeals processes should be available to the consumer following decisions on internal appeals. External appeals should allow for input from the patient's physician and the licensed professional providing therapy services. External appeals should be adjudicated in a timely fashion.

Contact Information

New York State Speech-Language-Hearing Association, Inc.

Marcy Savage
c/o Weingarten, Reid and McNally
One Commerce Plaza, Suite 402
Albany, NY 12210
518-465-7330
marcys@lobbywr.com

New York Physical Therapy Association

Kelly Garceau, Assistant Director
5 Palisades Drive, Suite 330
Albany, NY 12205
518-459-4499
kgarceau@nypta.org

New York State Occupational Therapy Association, Inc.

Jeffrey Tomlinson, OTR, MSW, FAOTA
Legislative & Government Relations Coordinator
119 Washington Ave., 2nd Floor
Albany, NY 12210
914-310-0247
jefflt@prodigy.net