



Improving State Coverage of Habilitation Services: Step-by-Step Guide for State Advocacy

Background

The Affordable Care Act (ACA) requires coverage of 10 essential health benefits, including rehabilitative and habilitative services and devices. The U.S. Department of Health and Human Services (HHS) formally adopted definitions for *habilitation* and *rehabilitation* for the consumer glossary of insurance terms. This toolkit was established for state associations to advocate for comprehensive coverage of these important rehabilitation and habilitation services and devices.

Federal Regulatory Definitions

Habilitation: *health care services and devices that help a person keep, learn, or improve skills and function for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.*

Rehabilitation: *health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.*

HHS clarified that devices must be covered for both habilitation and rehabilitation.

HHS also required that in 2017 habilitation must be provided at least on par with the established coverage of rehabilitation services. Prior to implementation of the new rule, states or, in the absence of a state definition, health plans had the option to define *habilitation* on their own.

Opportunity for Advocacy

Even though HHS has mandated coverage of rehabilitative and habilitative services and devices, some states' coverage of these important services is not comprehensive. ASHA wants to assist state associations to advocate for these services by providing the necessary materials through this guide.

The new federal requirements establish a floor for coverage of habilitative services and devices that did not exist previously. This is a new opportunity to expand coverage and access in your state.

Implementation Time Frame

HHS's definition of *habilitation services and devices* applies to qualified health plans beginning in 2016, with additional provisions (notably separate visit limits for habilitation and rehabilitation) applying in 2017.

States were required to pick their 2017 base-benchmark plan by the end of June 2015. If they did not choose a plan, the default benchmark plan became the largest (by enrollment) small employer plan offered in the state.

The advocacy window remains open through implementation because current and new benchmark plans must be supplemented to meet the new federal requirements.

Advocacy Outreach

Take time to reach out to the appropriate people at the state level for your advocacy efforts. There can be several layers involved. Individuals you will want to contact may include:

- Health insurance **marketplace administrators**
 - Depending on your state, the marketplace may be federally run, state run, or a combination of the two.
 - How your marketplace is run will determine who you need to focus your specific exchange advocacy efforts on.
 - Refer to the Kaiser Family Foundation's Interactive Guide to determine your state's marketplace type. (See <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/#map>.)
- **Administrators** who may be the liaison between the exchange and the governor and often work out of the governor's office
- **Regulators** at your state's department of insurance with authority over private health plans
- **Legislators** who may need to change the state's statute to comply with the new federal requirements
- Like-minded **state associations** representing consumers and providers

Step-by Step Advocacy Guide

Step 1: Inform

- Make sure your state is aware of the federal habilitative services requirements for the coverage and definition of *habilitation*, including devices.
- Communicate with your state association membership, lobbyists, and grassroots organizations regarding issues of importance and provide them with talking points—emphasize that the federal definition is a “floor” for state services. This ensures your leaders and members are speaking with a similar voice.

Step 2: Identify Issues

- Monitor and track how habilitative and rehabilitative services are covered in your state, specifically related to current policy and plans for 2016, 2017, and beyond.
- Analyze the benchmark plan in your state. All states have a current benchmark and a new base benchmark for 2017 plans, which was selected by June 30, 2015.
- Establish whether coverage is meeting enrollees’ needs in the area of your members’ services and, if coverage is inadequate, develop recommendations for supplementing the benchmark plan to meet federal requirements, at a minimum. States can mandate additional coverage beyond the federal requirements, which is the floor for coverage.

Step 3: Develop a Systematic Advocacy Plan

- Identify key areas where advocacy is needed to ensure the base benchmark plan is supplemented adequately.
- Identify gaps in coverage and areas where needs aren’t being met beyond the federal minimum. Include those state-specific recommendations in your comments to decision makers.

Step 4: Mobilize Your State Association Leaders and Members

- Implement a process for stakeholders to provide input on state decisions regarding rehabilitative and habilitative services and devices.
- Collaborate with other like-minded state associations and groups. Likely partners could be those representing occupational therapy, physical therapy, and consumer advocacy groups.
- Engage your lobbyists and advocacy leaders in taking advantage of this opportunity to expand coverage of member services. Have your lobbyists or volunteer advocates arrange meetings with the key individuals listed above and walk them through the recommendations in the guide. Add as much information as possible about the importance of coverage and its impact in your state.
- Empower your membership by providing information on key issues and encouraging meeting attendance. For example, provide access to the guide or the included Habilitation Talking Points Fact Sheet.
- Reach out to legislators, regulators, and the health insurance marketplace, if applicable, in your state using the coverage recommendation guide provided
- Consult ASHA for assistance coordinating and/or advocating for improved coverage of habilitative services in your state!

Habilitation Talking Points Fact Sheet

- Federal definition for habilitation effective January 1, 2016: health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- Qualified Health Plans must cover rehabilitative and habilitative services and devices under HHS' uniform definitions.
- Beginning in 2017, additional provisions for separate visit limits for habilitation and rehabilitation apply.
- As of 2017, Qualified Health Plans may not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services.
- Visit limits for habilitative services may not be combined with and must be separate and distinct from the rehabilitative services benefit for 2017.
- Habilitative services and devices are typically appropriate for individuals with many types of neurological and developmental conditions that—in the absence of such services—prevent them from acquiring skills and functions over the course of their lives.
- HHS has stated that state benefit mandates enacted to define and supplement habilitative services to meet the new federal requirements are part of the essential health benefit; states ***do not*** defray the cost. This means that if a state wants to improve coverage for habilitative services and devices through a state mandate, the Qualified Health Plans would have to include these enhanced services as a part of the essential health benefit.

Habilitation and Rehabilitation Advocacy Template Letter

[Date]

[Name]

[Title]

[Organization]

[Address]

[City, State Zip]

RE: Coverage of Rehabilitative and Habilitative Services and Devices

Dear:

The [State Association Name Here (Abbreviation)] is the [State] association that represents audiologists, speech-language pathologists, speech, language and hearing scientists, audiology and speech-language pathology support personnel and students and advocates on behalf of those individuals that we serve. The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 182,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. [St. Assn ABBREV] is working collaboratively with ASHA to advocate for appropriate coverage of audiology and speech-language pathology services as essential health benefits under health plans subject to the requirements of the Patient Protection and Affordable Care Act of 2010 (ACA).

The ACA requires all non-grandfathered health insurance plans offered in the small group and individual markets, both in and outside of the state health insurance marketplaces, to provide benefits in 10 essential health benefit (EHB) categories. Rehabilitative and habilitative services and devices is one of the EHB required categories. Audiologists and speech-language pathologists hold an integral role in providing medically necessary services to clients requiring rehabilitative and habilitative care covered under one of the EHB categories. Beginning in 2016, Qualified Health Plans must cover habilitative services and devices under the Department of Health and Human Services' (HHS) uniform definition. Additional provisions for separate visit limits for habilitation and rehabilitation apply beginning in 2017.

Federal Definition of *Habilitative Services*

HHS recently adopted a uniform definition for *habilitation* that states are required to use as the floor in determining coverage for habilitation services and devices for individual and small employer health insurance plans beginning in 2016.

Habilitation services and devices—Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings¹.

¹ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-03751.pdf>

[St. Assn ABBREV] and ASHA have been working to ensure comprehensive coverage of audiology and speech-language pathology services for clients with chronic conditions and/or disabilities and fully supports the HHS uniform definition. Adopting a uniform definition minimizes the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Therefore, [St. Assn ABBREV] and ASHA urge all states to adopt a habilitation services and devices benefit that complies with the newly adopted federal definition.

Separate Visit Limits Required in 2017

In the 2016 Notice of Benefit and Payment Parameters (NBPP) final rule, HHS required that, beginning in 2017, Qualified Health Plans will not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. Furthermore, visit limits for habilitative services may not be combined with and must be separate and distinct from the rehabilitative services benefit. [St. Assn ABBREV] supports this policy and further requests that Qualified Health Plans offer separate visit limits for each of the therapies (e.g., speech therapy, physical therapy, occupational therapy) as they provide distinct services focused on different functional goals. It is not uncommon for an enrollee to require up to 20 visits in a 6-week timeframe for speech therapy alone, depending on the diagnosis and treatment plan.

Unnecessarily limiting or applying restrictive *medical necessity* definitions that do not evaluate a component of beneficiary function should not be used to prevent access to rehabilitation or habilitation services and devices. In addition, rehabilitation or habilitation benefits should not be subject arbitrary visit limits or other limitations or exclusions that do not take into account the beneficiary's functional needs or provide a pathway to care beyond the arbitrary limits when medically necessary. The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatments from a range of providers. Services are often considered medically necessary as long as:

- separate and distinct goals are documented in the treatment plans of physicians, nurses, and therapists providing concurrent services;
- specific services are non-overlapping; and
- each discipline is providing some service that is unique to the expertise of that discipline and would not be reasonably expected to be provided by other disciplines.

Coverage of Habilitative Services and Devices

Habilitation services and devices are typically appropriate for individuals with many types of neurological and developmental conditions that—in the absence of such services—prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood.² In addition, rehabilitative and habilitative devices typically prescribed by audiologists and speech-language pathologists include devices that aid in hearing and speech, including hearing aids, augmentative and alternative communication (AAC) devices, and other assistive technologies and supplies.

AAC devices are specialized devices, such as speech-generating devices, that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional.

² ASHA Speech-Language Pathology Medical Review Guidelines: www.asha.org/uploadedFiles/SLP-Medical-Review-Guidelines.pdf.

Hearing aids and assistive listening devices are medical devices that amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional. Examples of these devices include, but are not limited to, hearing aids, cochlear implants, and osseointegrated/bone-anchored hearing aids.

State Mandates to Supplement Habilitative Services and Devices Benefit

[St. Assn ABBREV] is pleased that HHS explained in the final rule that state benefit mandates enacted to define habilitative services are part of the essential health benefit—states *do not* defray the cost. (See page 226 of the NBPP³). This clarification allows states to address coverage gaps in their state. State mandates would not only enhance benefits, but would also improve access to habilitation services—Qualified Health Plans would need to cover these enhanced services.

Recommendations

All Qualified Health Plans must comply with the recently adopted federal definition for habilitation services and devices. Limitations, if any, should be applied separately to rehabilitation and habilitation. It is a violation of federal regulation to split an existing rehabilitation benefit in half and apply the same total visit limitation separately.

[St. Assn ABBREV] appreciates the opportunity to provide comments on this important topic. Please contact [State Hab Point Person], at [XXX-XXX-XXXX] or [e-mail], or Daneen Grooms, ASHA's director of health reform analysis and advocacy, at 301-296-5651 or by e-mail at dgrooms@asha.org, if you require additional information or clarification.

Sincerely,

[State President Signature]

[State President Name and Credentials]

³ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-03751.pdf>

ASHA Staff Contacts

For more information or advocacy assistance, please contact your state association's state liaison.

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For specific information on rehabilitative and habilitative coverage, please contact:

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