AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted via e-mail: marybethe.senkewicz@dc.gov

May 20, 2015

Mary Beth Senkewicz
Supervisory Attorney
DC Health Benefit Exchange
1225 Eye Street, NW
Suite 400
Washington, DC 20005

RE: 2017 Essential Health Benefit Benchmark Health Plan

Dear Ms. Senkewicz:

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. We understand that the DC Health Benefit Exchange (HBX) will select the 2017 Essential Health Benefit (EHB) Benchmark plan and would like to submit comments on the definition and coverage issues involving the benefit category of "rehabilitative and habilitative services and devices."

ASHA applauds the Department of Health and Human Services (HHS) for recently adopting a uniform definition for habilitation that states are required to use as the floor for determining coverage of 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 settings.*

ASHA has been actively working to ensure comprehensive coverage of audiology and speech-language pathology services for patients with chronic conditions and/or disabilities and fully support the HHS uniform definition. Adopting a uniform definition minimizes the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Therefore, ASHA urges the DC HBX to adopt a habilitation services and devices benefit that complies with the newly adopted federal definition.

HHS also finalized in the 2016 Notice of Benefit and Payment Parameters (NBPP) final rule that, beginning in 2017, qualified health plans will be required to not impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of

rehabilitative services. In addition, visit limits for habilitative services may not be combined with and are separate from rehabilitative services. ASHA supports HHS' policy to no longer combine visit limits and further requests that benchmark plans offer separate visit limits for each of the therapies (i.e., speech, physical, occupational) 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.

Additionally, medical necessity definitions should not be used to prevent access to rehabilitation or habilitation altogether, or stop rehabilitation or habilitation prematurely through arbitrary visit limits or other limitations or exclusions. The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatment 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;
- the 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.

Before the adoption of the recently finalized federal definition for habilitation services and devices, the District of Columbia adopted a mandate requiring individual and small group health plans to provide habilitation services for individuals ages 21 and under. ASHA has observed that DC does not require coverage for hearing aids or cochlear implants by the benchmark plan and requests that hearing aids and cochlear implants be specified in the mandate to ensure coverage of these medically necessary devices. Children diagnosed with hearing loss through the Early Hearing Detection and Intervention (EHDI) program require amplification not only to ameliorate the hearing loss, butalso to develop language on par with normal hearing children. This has been well established by the Joint Committee on Infant Hearing.[1]

While we are pleased that habilitation coverage for individuals ages 21 and under is not limited to a specific condition or illness, we do not believe coverage for habilitation services and devices should be limited by age. HHS clarified in the 2016 NBPP final rule (see pages 266-267) that labeling a benefit as a "pediatric service," thereby excluding adults, is a potentially discriminatory practice . Habilitation—as well as rehabilitation—is essential to hearing health, mental health, and independent living for adults.[2] It's important to note 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 NBPP). This clarification allows states to supplement the habilitation benefit if it does not comply with the newly adopted federal definition. For example, DC could expand coverage for habilitation services and devices beyond the age of 21 and provide coverage for hearing aids and cochlear

[1] Joint Committee on Infant Hearing Position Statements: http://www.jcih.org/posstatemts.htm.
[2] Yueh B, Shapiro N, MacLean CH, Shekelle PG. Screening and management of adult hearing loss in primary care: Scientific review. JAMA. 2003; 289(15): 1976–1985.

implants under habilitation through a state mandate. The enhanced benefits would then become a part of the essential health benefit as a mandated benefit and the selected benchmark plan would be required to cover these services. State mandates for habilitation would not only enhance benefits, but would also improve access to habilitation services. Although hearing aids would be included as part of the EHB for habilitation services, hearing aids are also prescribed by audiologists for rehabilitation. As such, it is inappropriate to limit hearing aids to habilitation only.

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.[3] In addition, rehabilitative and habilitative devices typically prescribed by audiologists and speech-language pathologists include hearing aids, augmentative and alternative communication (AAC) devices, such as speech-generating devices, which aid in hearing and speech, and other assistive technologies and supplies.

AAC devices are specialized devices that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices. 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.

ASHA appreciates the opportunity to provide comments on this important topic. Please contact Susan Adams, JD, ASHA's director of state legislative and regulatory advocacy, at 301-296-5665 or sadams@asha.org, or Daneen Grooms, MHSA, ASHA's director of health reform analysis and advocacy, at 301-296-5651 or dgrooms@asha.org, if you require additional information or clarification.

Sincerely,

Judith L. Page

Judith L. Page, PhD, CCC-SLP
2015 ASHA President

[3] ASHA Speech-Language Pathology Medical Review Guidelines: http://www.asha.org/uploadedFiles/SLP-Medical-Review-Guidelines.pdf