

Hello, my name is Rose and I am an occupational therapist working as a rehabilitation admissions liaison for an inpatient rehab facility. I use my skills as an occupational therapist to evaluate and assess patients who have undergone substantial medical events for their ability to meet the CMS mandated criteria for admission to an inpatient physical rehabilitation program. My education and training is an occupational therapist to make me particularly well suited for this position.

As part of my daily duties, I am an advocate for patients to receive intensive therapy services to promote their healing along the healthcare and rehabilitation continuum. I work directly with managed care in continuing care organizations requesting prior authorization, continued stay authorization and providing admissions and discharge notifications. I work in collaboration with an interdisciplinary team, which includes psychiatry, Allied health care, rehabilitation nurses, social workers, etc.

I wish I could tell you that each of my patients receive the same treatment, move through the system equally, and are given equal opportunity to access healthcare, but I am sure we all know that is not true. I can look at their payor source and know immediately how quickly this patient will be able to admit to my program and it's not because of barriers internal to our process, but because of the payor itself. I can also tell you with fair confidence how likely they will be to get denied the services they're due simply because they are assigned one organization versus another to manage their healthcare. This is NOT right.

About 20% of the referrals to my program are Medicaid with 15% of those being managed Medicaid. 60% of the denials were from the same CCO, even though that CCO only represents 30% of our referrals. The reason I bring this up, is that I think it is a good example of the fact that CCO's are not managing their members' benefits the same across the board. Some have much more stringent guidelines than others. Some require much more arduous work on behalf of the facility to continue to approve our services. As a consumer, I would have no idea what to ask or how to determine whether the CCO that I am assigned to is supportive of me or my care needs, places unnecessary restrictions that prevent my ability to access care, or just plain hard to work with for my healthcare team or myself.

All this to say, I am writing in support of HB 2517. I believe regardless of the CCO you are assigned, benefits that are due should be administered with equality, transparency, and plain language. The organizations such as mine that advocate for patient access to care should not have to jump through unnecessary hoops, wait extraordinary lengths of time, and have patient's cases put through unclear sets of guidelines that are not evenly weighed across cases/reviewers in order to get people the necessary care they need. At the end of the day we are all in this business to provide care to people. Of course it is our responsibility to do this in a way that is fiscally sound, but it must also be ethically sound and reasonable. Please support HB2517 and bring increased transparency to our healthcare system.