



October 6, 2016

VIA ELECTRONIC SUBMISSION

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9934-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Public Comments on HHS Notice of Benefit and Payment Parameters for 2018 (RIN 0938-AS95)

Dear Administrator Slavitt:

The undersigned members of the Habilitation Benefits (HAB) Coalition, the Coalition to Preserve Rehabilitation (CPR), and the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition appreciate the opportunity to comment on the proposed rule *HHS Notice of Benefit and Payment Parameters for 2018*¹ (the Proposed Rule).

The HAB Coalition is a group of national nonprofit consumer and clinical organizations focused on securing appropriate access to, and coverage of, habilitation benefits within the category known as “rehabilitative and habilitative services and devices” in the EHB package under the Patient Protection and Affordable Care Act (PPACA), Section 1302. CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function. ITEM is a coalition of national organizations dedicated to improving access to and coverage of assistive devices and technologies for people of all ages with disabilities and chronic conditions.

This proposed rule sets forth benefit and payment parameters, provisions related to the risk adjustment program, cost-sharing, and user fees for Federally-facilitated and State-based Exchanges, as well as

¹ *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018*; 81 Fed. Reg. 61,456 (September 6, 2016). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-09-06/pdf/2016-20896.pdf>.

many other policies implementing the Affordable Care Act. This comment letter will focus on key proposed provisions that relate to enrollees in need of medical rehabilitation and post-acute care, including network adequacy, cost-sharing, standardized options, and risk adjustment.

For Qualified Health Plan (QHP) enrollees to benefit from appropriate rehabilitation, we believe that QHPs sold through Exchanges must adhere to patient-friendly network adequacy standards that provide ample access to the full complement of rehabilitation and habilitation service and device providers, professionals and facilities that provide both primary and specialty care. These services should be provided based on the individual's needs, prescribed in consultation with an appropriately credentialed clinician, and based on the assessment of an interdisciplinary rehabilitation/habilitation team and resulting rehabilitation/habilitation plan of care.

In addition to physically accessible primary care, such provider networks should include physician specialty services such as physical medicine and rehabilitation, neurology, orthopedics, rheumatology, and many other subspecialties, including physicians serving pediatric populations. They should include post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs), skilled nursing, home health, and home and community based services. They should also include physical, occupational and speech therapy, audiology services, and recreational and respiratory therapy. Durable medical equipment specialists and appropriately credentialed prosthetists and orthotists must also be included in provider networks as well as clinicians engaged in psychiatric rehabilitation, behavioral health services, cognitive therapy, and providers of psycho-social services provided in a variety of inpatient and/or outpatient settings.

Presently, our members know of many QHP issuers that offer limited provider networks that restrict access to many of these types of providers. Our comments below provide suggestions to remedy that situation.

I. Network Breadth Indicator (Section 156.230)

In the Proposed Rule, CMS states that, for the 2017 benefit year, it will pilot a network breadth indicator in certain States on HealthCare.gov to denote a QHP's relative network coverage. This network breadth indicator will be calculated as described in the Final 2017 Letter to Issuers in the Federally-Facilitated Marketplaces. The Proposed Rule also states that CMS will make this network breadth classification available to consumers in those states at the point of plan comparison. The results of the pilot will determine if HHS expands it to more states for 2018. For the 2018 plan year, HHS is considering whether to incorporate more specificity into these indicators, and, in particular, how to identify for consumers whether a particular plan is offered as part of an integrated delivery system.

We support CMS's proposal to provide a rating of each QHP's relative network coverage on www.HealthCare.gov, as it provides beneficiaries greater knowledge into the breadth and quality of these networks, and provides greater accountability to QHPs. That said, we further suggest the following:

Timely and prominent publication. For CMS's proposed QHP network breadth indicator to have its intended effect of informing enrollees of the actual health care providers that they can timely access, we recommend that CMS's calculation of each QHPs' network breadth indicator be completed, as well as published, before open enrollment begins each year. Once prospective QHP enrollees can access

the government website to choose and then enroll in a QHP, the website should prominently display both:

- The full list of primary care providers included within each QHP’s provider network; and
- A list of specialty care providers in each QHP’s provider network, including the wide range of providers of rehabilitation and habilitation services and devices.

Additionally, we offer the following specific recommendations:

- The rating system should be clear and concise for consumers to understand—using standards such as “small,” “medium,” and “large” provider networks. HHS should conduct consumer testing to inform the development of this rating system.
- Consider providing separate ratings by categories of adult and pediatric providers that would add up to an overall rating of network breadth.

II. Additional Proposed Metrics for Assessing Network Breadth

In addition to the CMS’s implementation of the Network Breadth Indicator, we suggest that CMS adopt the following metrics for assessing a QHP’s Network Adequacy:

Application of time and distance standards. First, we believe that any assessment of network breadth should be broad enough to account for the medical needs of QHP enrollees residing in rural areas. Network adequacy standards should ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under the plan, and recognize that many people with disabilities lack transportation options. QHP issuers should be required to collect data on the average time it takes for their enrollees to secure an appointment with each of their network’s providers. Furthermore, we note that time and distance standards should not always be used as the sole measure of network breadth, given shortages of some types of providers and the regionalization of some specialty care.

Broad Networks Help Ensure Access to Appropriate Rehabilitative and Habilitative Care. A wide range of rehabilitation/habilitation provider types will help ensure that enrollees have access to the appropriate intensity and scope of needed rehabilitation services. For instance, too often enrollees across the country are diverted into nursing homes rather than inpatient rehabilitation hospitals and units because their health plans do not contract with a sufficient number of these providers. Too often, enrollees with brain injuries do not receive the intensive longer term services they need because health plans do not contract with specialized brain injury treatment programs. And too often, suppliers without sufficient training, expertise or credentials are called upon to provide highly complex prosthetic limb care or other specialized habilitative and rehabilitative services and devices that appropriately credentialed providers should be providing.

Securing broad range of providers and access to specialized rehabilitation/habilitation services. We urge CMS to adopt a network adequacy standard that requires health plans to have a full range of adult and pediatric providers in-network capable of providing all covered services, from preventative care to the most complex care. Networks should also be able to contract with specialists (adult and pediatric), and those that provide specialized rehabilitation and habilitation services specifically, without additional cost-sharing burden to consumers. In addition to many of the specific types of services already mentioned, these services also include: brain injury treatment programs including

residential/transitional programs, prosthetists, orthotists, durable medical equipment (DME) providers, therapies, and providers of complex rehab technology (CRT). Out-of-network exceptions and appeals processes, as well as up-to-date provider directories, are critical to patient access, but they cannot be a substitute for robust provider network standards.

QHPs should include in their assessment of network adequacy a measurement to ensure access to community-based providers with documented experience in serving adults and children with disabilities and chronic conditions. People with disabilities should have access to disability-specific specialists and services, in settings that are physically accessible, and with a choice of providers—primary, specialty, and subspecialty—no matter which QHP they are enrolled in.

We believe strongly that the adequacy of a plan's provider network dictates the level of access to benefits otherwise covered under the health plan. If a plan covers a benefit but limits the number of providers or specialists under that plan, coverage will be curtailed through a lack of access to providers with sufficient expertise to treat the patient. It is well established that health plans often use limitations in their provider networks to manage their benefit coverage costs.

Seamless care transitions. We support an emphasis on seamless care transitions that ensure that enrollees undergoing a course of treatment can continue their relationship with their provider during that treatment episode. Specifically, new enrollees in the midst of an active course of treatment should be able to continue that treatment with their current providers for up to 90 days, even if those providers are not in their new plan's network. Patients in the midst of a treatment episode for a serious or life-threatening condition have a strong incentive to seek to enroll in a plan that includes all of their current health care providers.

Particularly given the proliferation of narrow networks, however, patients—particularly those with complex or chronic conditions—may not be able to find a plan that includes all of the specialists and other providers who treat them. A sufficient transition period would allow patients to identify and schedule appointments with new health care professionals who participate in their new network. We encourage HHS to consider that patients in this situation may not be voluntarily switching plans—that is, they may be switching due to the discontinuation of their current plan.

Credentialing. We believe that all providers within networks must be appropriately certified and licensed by the appropriate bodies. Private accreditation from accreditation agencies who understand rehabilitation and habilitation is a good indicator of quality providers. For example, the Commission on Accreditation of Rehabilitation Facilities (CARF) is a dominant accreditor of rehabilitation programs across the spectrum of service providers. Its standards include peer-driven network adequacy requirements that should be considered by QHPs as they design their rehabilitation and habilitation provider networks.

III. Standardized Options (Section 155.20)

The Proposed Rule adds three new sets of standardized options for the 2018 plan year (Tables 12, 13 and 14). Table 13 is a set of standardized options designed to work in states that require that cost sharing for physical therapy, occupational therapy and speech therapy be no greater than the cost sharing for primary care visits. While these proposals only apply to the standardized option, we commend CMS for recognizing the importance of access to rehabilitation therapy services. We also appreciate CMS's interest in preventing QHPs from creating financial disincentives that place burdens

on enrollees which discourage access to therapy services. If finalized, these policies will increase consumer access and limit the financial barriers to rehabilitation care.

However, in Tables 12-14, labeled “Proposed 2018 Standardized Options,” CMS lists “Speech Therapy” and “Occupational Therapy/Physical Therapy” but does not list habilitative services, indicating that rehabilitative services are subject to coinsurance but habilitative services are not.² We request clarification on this point, and suggest that *both rehabilitative and habilitative services and devices* in the Exchanges be exempt from co-insurance that differs from primary care co-insurance. We request:

- this exemption based on the understanding that habilitation and rehabilitation are to be treated in the same manner but as separate benefits;
- that occupational therapy and physical therapy be considered separate and distinct therapy services and not lumped together for purposes of the Standardized Options, similar to how rehabilitative speech therapy is listed as a separate benefit;
- that cost-sharing be reasonable so as not to serve as a barrier to consumers in need of necessary therapy services; and,
- that rehabilitative and habilitative “devices” have the same coinsurance protections as “services” under these Standardized Options.

IV. Disability Discrimination in Plan Design

While we applaud the administration for raising issues involving cost-sharing, we are disappointed that this Proposed Rule does not address QHP discrimination in benefit design based on disability and other factors. The Notice of Benefit and Payment Parameters Final Rule issued on February 27, 2015 made great progress in defining the term “rehabilitative and habilitative services and devices.” But additional federal regulation is necessary to interpret the disability discrimination provisions of Section 1302(b) and Section 1557 of the Affordable Care Act.

Caps on rehabilitative and habilitative services and devices. We were hoping that CMS would elaborate on this benefit category in this year’s proposed rule, particularly with respect to plan benefit design that potentially violates the disability discrimination provisions of the ACA, but the proposed rule did not adequately address this important issue. For instance, the vast majority of QHPs have instituted arbitrary caps in certain rehabilitative and habilitative health benefits, such as one-size-fits-all outpatient therapy caps. Plans typically avoid strict dollar caps in therapy benefits, which are prohibited under the ACA, but instead impose visit limits. These visit limits (e.g., 20 therapy visits per episode) are not established based on evidence-based medicine and do not typically include an exceptions process—as the Medicare program does—to ensure that enrollees who need more therapy than the average patient obtain access to continued therapy.

We request CMS to include in the final rule an admonition to QHPs that these types of arbitrary caps in rehabilitation benefits—when no exceptions process is available to the patient—are not consistent with patient-centered care or, more importantly, the non-discrimination requirements under the ACA for plan design under both Sections 1302 and 1557. We believe that if states choose to impose caps in rehabilitation or habilitation therapy services, they must not rely on disability-based distinctions and any such caps must be justified by legitimate actuarial data or actual or reasonably anticipated experience. In addition, there must be an *exceptions process* to meet the needs of individuals who

² *Id.* at 61493-61495.

require more therapy than the cap allows for the person with average therapy needs. Imposing caps on coverage can easily serve as de-facto annual monetary caps on coverage, which violate ACA requirements.

We, therefore, strongly urge CMS to include in the final rule a statement that QHPs cannot rely on the fact that arbitrary caps in therapy benefits, without a reasonable exceptions process where an individual determination of medically necessary services is available to the patient, comply with the disability discrimination protections of Sections 1302(b) and Section 1557 of the ACA.

This same exceptions process should also be available when arbitrary caps are applied to habilitation services as well as rehabilitation and habilitation *devices*. For instance, an exceptions process should be available when:

- a child's condition requires more habilitation services than the cap permits
- an enrollee requires an advanced prosthetic limb in order to ambulate and achieve full function but a blanket exclusion prohibits coverage; and,
- an individual requires a particular type of wheelchair or wheelchair component in order to return to work or reduce the likelihood of pressure ulcers but a cap in DME benefits prohibits access and coverage.

V. Clarification of Habilitation Services and Devices under Benchmark Coverage

The 2016 Notice of Benefit and Payment Parameters (NBPP) Final Rule indicates that states can supplement via state mandate the state's base-benchmark plan at no cost to the state, if the mandate is intended to meet a uniform definition of benefits required by federal regulation. This is particularly important in terms of habilitation benefits. The 2016 NBPP clearly states, "States are required to supplement the benchmark plan if the base benchmark plan does not include coverage of habilitative services as defined in this final rule. We are codifying the definition of habilitative services as a minimum for States to use when determining whether plans cover habilitative services." 2016 NBPP at page 10,811.

The federal regulations define a uniform definition of "habilitative services and devices," as follows:

"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." 2016 NBPP at 10,871.

The Notice of Benefit and Payment Parameters for 2017 Final Rule states the following: "We are affirming that the State has the flexibility to define habilitative services; however, the State must use a reasonable interpretation as to what services are habilitative." 2017 NBPP at 12,244. However, there is confusing language in the preamble of that same rule that seems to suggest that states may only define habilitative services if the state's base-benchmark plan does not include *any* coverage of habilitative services, and it appears that some states are now interpreting the requirement this way.

The uniform definition serves as a minimum standard for covering habilitative services, as the regulations cited above state. Therefore, if a state's base-benchmark plan does not provide coverage of

habilitative services or provides inadequate coverage, states may define the benefit, but must use the uniform definition as a minimum standard and should not incur the cost of this federal requirement. For instance, if a state determines that hearing aids for children with hearing loss is a “health care service or device that helps a person keep, learn, or improve skills and functioning for daily living” under the habilitation benefit, and passes a state benefit mandate to that effect, the state should not be required to contribute toward the cost of that mandate.

We urge CMS to clarify in the final rule that the language of the 2016 NBPP is the operative language that controls this scenario and that CMS is not modifying its previous interpretation.

VI. Cost-Sharing (Section 156.230(e))

We support CMS limiting “surprise bills” for out-of-network services in § 156.230(e), proposed in the 2017 Payment Notice and scheduled to begin in benefit year 2018.

We believe that when an individual must use an out-of-network provider because there is no provider available in-network that is capable of providing a covered benefit, or no provider that is physically or programmatically accessible to the individual, that person must not be penalized by the health plan for accessing out-of-network providers. Cost-sharing and other requirements for the receipt of out-of-network care should mirror the same protections set forth by the plan for in-network care—assuming the network does not contain the type of specialist in need, or access to physically accessible specialists within a reasonable distance from the patient’s home or place of employment. Plans should demonstrate that they maintain an adequate and timely approval process for out-of-network services, utilize appropriate clinical standards in evaluating requests, and have a clear, transparent, and timely appeals process for denied services.

Specifically, we believe that consumer cost-sharing paid to a provider should count toward the maximum out-of-pocket (MOOP) limit and that consumers not be subject to balance billing. This is necessary to ensure that consumers are truly held harmless when they lose access to a provider at some point during their plan year, when they have no ability to switch to a different plan.

VII. Risk Adjustment

We recognize that the risk adjustment process as highlighted in the Proposed Rule is very complex and does not wish to comment on the methodology of developing this process. However, we stress that it is very important that risk adjustment mechanisms appropriately accommodate for the needs of individuals with disabilities and chronic conditions. The alternative would mean applying an unfair standard of care to these populations (i.e., a standard of the average patient, rather than a more complex patient), thus increasing the chances of stinting on patient care to those who need care the most.

We greatly appreciate your attention to our concerns involving this important proposed rule. Should you have further questions regarding this information, please contact Peter Thomas or Steve Postal, coordinators for the CPR, ITEM and HAB Coalitions, by emailing Peter.Thomas@ppsv.com or Steve.Postal@ppsv.com, or by calling 202-466-6550.

Sincerely,

Supporting Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Cochlear Implant Alliance
American Congress of Rehabilitation Medicine
American Foundation for the Blind
American Heart Association/American Stroke Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Network of Community Options and Resources (ANCOR)
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association for Education and Rehabilitation of the Blind and Visually Impaired (AER)
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
Autism Speaks
Brain Injury Association of America
Caregiver Action Network
Center for Medicare Advocacy
Children's Hospital Association
Christopher and Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund (DREDF)
Easterseals
Epilepsy Foundation
Falling Forward Foundation
Family Voices
Hearing Loss Association of America
Institute for Matching Person and Technology
Lakeshore Foundation
The National Assn of County Behavioral Health and Developmental Disability Directors
The National Assn for Rural Mental Health
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Council for Behavioral Health
National Disability Rights Network
National Multiple Sclerosis Society
National Stroke Association
Paralyzed Veterans of America
The Simon Foundation for Continence
Spina Bifida Association
Unite 2 Fight Paralysis
United Cerebral Palsy
United Spinal Association