December 1, 2016

**VIA ELECTRONIC MAIL**

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

**RE: Public Comments on Draft 2018 Letter to Issuers in the Federally-facilitated Marketplaces**

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 *Draft 2018 Letter to Issuers in the Federally-facilitated Marketplaces* (the Letter to Issuers).

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 Letter to Issuers offers operational and technical guidance to help qualified health plans (QHPs) participate in the Federally-facilitated Marketplaces (FFMs). This comment letter will focus on key proposed provisions that relate to enrollees in need of rehabilitation, habilitation and post-acute care, including network adequacy, standardized options, and provider transitions.

## I. Standardized Options (Chapter 1, Section 5)

We support CMS' proposal to develop a standardized option at each metal level (i.e., bronze, silver, and gold) to simplify consumers' health insurance shopping experience in the federally-facilitated marketplaces (FFMs). That said, we offer the following suggestions regarding Standardized Options:

**Make the standardized option mandatory for QHPs.** In the 2018 Payment Notice, HHS is proposing that adoption of the standardized option be at the discretion of the QHP and is not mandatory. We understand that HHS elected not to make this mandatory because the cost-sharing structure may not be well tailored for all states and that some QHPs may have difficulty due to operational constraints. However, we believe that the standardized option should be mandatory because it is designed to provide clear, uniform, and transparent information about health insurance options and related costs of coverage. Simplifying the consumer plan selection process will provide consumers with the key details they need to make informed decisions.

Furthermore, the Standardized Options section in the letter to issuers did not contain specific references to habilitative and rehabilitative services and devices. 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 in the 2018 Payment Notice Proposed Rule;
- 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.

## II. Network Adequacy Standard and Certification Review (Chapter 2, Section 3(i))

We noticed that post-acute care facilities, including the wide range of providers of rehabilitation and habilitation services and devices, are not listed as specialties for which the time and distance standard would apply. For post-acute care services, the access limitations of high-level inpatient services, such as inpatient rehabilitation facilities, may result in an inappropriate discharge to home and a subsequent hospital readmission due to the lack of skilled services. Therefore, we request that CMS create time and distance standards for post-acute care facilities, including the wide range of providers of rehabilitation and habilitation services and devices.

We also 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.

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.

## III. Provider Transitions (Chapter 2, Section 3(ii))

The Letter to Issuers mentions two provisions from the 2017 Payment Notice Final Rule. The first provision, codified at 45 CFR 156.230(d)(1), requires QHP issuers to make a good faith effort to provide written notice of termination of a discontinued provider 30 days prior to the effective date of the change or otherwise as soon as practicable to all enrollees that are seen on a regular basis by the provider or that receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for a cause or without cause, or due to a non-renewal. The second provision, codified at 45 CFR 156.230(d)(2) requires issuers, in cases where the provider is terminated without cause, to allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

We support both proposals. 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.

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.

## IV. Network Transparency (Chapter 2, Section 3, Subsection iv)

According to the Letter to Issuers, CMS will identify network breadth based on analysis of QHP provider and facility data submitted as part of the plan year 2018 certification process. This analysis will compare an issuer's contracted providers to the number of specific providers and facilities included across all QHP networks available in a county. The rating will focus on hospitals, adult primary care, and pediatric primary care with a separate classification for each of the three categories. **We support this proposal and recommend that CMS also include post-acute care facilities, including the wide range of providers of rehabilitation and habilitation services and devices, as providers to focus on when determining a network's breadth.**

## V. Discriminatory Benefit Design (Chapter 2, Section 10)

As stated in the Letter to Issuers, 45 CFR 156.125(a) states that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

**We believe that 45 CFR 156.125(a) prohibits QHPs from limiting coverage for habilitation and rehabilitation services to any particular condition and from arbitrarily limiting access to services for any single treatment.**

Caps on rehabilitative and habilitative services and devices. We were hoping that CMS would elaborate on this benefit category in this year's Letter to Issuers, particularly with respect to plan benefit design that potentially violates the disability discrimination provisions of the ACA, but the Letter 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 admonish 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 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 issue a statement that QHPs: 1) cannot rely on caps in therapy benefits, habilitation services, and rehabilitation and habilitation *devices*, without a reasonable exceptions process where an individual determination of medically necessary services is available to the patient, and 2) must bring any limitation on services in compliance with the disability discrimination protections of Sections 1302(b) and Section 1557 of the ACA.

We similarly believe that 45 CFR 156.125(a) prohibits QHPs from limiting coverage of hearing aids to enrollees who are six years of age and younger because there may be some older enrollees for whom a hearing aid is medically necessary. Hearing aids and similar technologies are "rehabilitative or habilitative devices" and, as such, must be covered under every state's EHB benefit package for 2018. Failure to cover hearing aids and similar technologies violates both the ACA's statute and regulations. Failing to cover hearing aids discriminates against people with hearing loss. In addition, coverage of hearing aids for children only and not for adults violates the ACA prohibition against discrimination in plan design based on age.

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We greatly appreciate your attention to our concerns involving this Letter to Issuers. 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@powerslaw.com or Steve.Postal@powerslaw.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 Heart Association/American Stroke Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
The Arc of the United States
Association for Education and Rehabilitation of the Blind and Visually Impaired
Association of Assistive Technology Act Programs (ATAP)
Association of Rehabilitation Nurses
Brain Injury Association of America
Caregiver Action Network
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Easterseals
Falling Forward Foundation
Family Voices
Institute for Matching Person & Technology
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of County Behavioral Health & Developmental Disability Directors
National Association for Rural Mental Health
National Association of State Head Injury Administrators
National Disability Rights Network
National Multiple Sclerosis Society
Paralyzed Veterans of America
Rehabilitation Engineering and Assistive Technology Society of North America
The Simon Foundation for Continence
Spina Bifida Association
Unite 2 Fight Paralysis
United Cerebral Palsy
United Spinal Association