March 7, 2017

Secretary Thomas E. Price, MD
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; Market Stabilization [CMS-9929-P]

Dear Dr. Price:

The Steering Committee of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the proposed rule, *Patient Protection and Affordable Care Act; Market Stabilization.* 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. Our comments to this proposed rule focus on network adequacy, continuous coverage, open and special enrollment, and rehabilitative services and devices.

Network Adequacy
In the Proposed Rule, CMS proposes changing network adequacy review for qualified health plans (QHPs), specifically placing a greater reliance on state reviews. Additionally, CMS proposes a change to reviewing network adequacy in States that do not have the authority and means to conduct sufficient network adequacy reviews. In those States, CMS would, for the 2018 plan year, apply a standard similar to the one used in the 2014 plan year. As HHS did in 2014, in States without the authority or means to conduct sufficient network adequacy reviews, CMS would rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. CMS would recognize three accrediting entities for network adequacy reviews for the 2018 plan: the National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care. These are the same three entities that HHS has previously recognized for the accreditation of QHPs.

CPR supports maintaining and strengthening *federal* network adequacy standards, including the following:

Broader application of time and distance standards. First, CPR believes that time and distance standards should be broad enough to account for the medical needs of QHP enrollees residing in more rural areas, and that those enrollees must travel greater distances to access IRFs. 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.

Network sufficiency and the NAIC Model Act. While the language regarding network adequacy in the National Association of Insurance Commissioners' (NAIC) Model Act has much broader application than rehabilitation services alone, CPR supports the factors that NAIC suggests comprise "network sufficiency," including: provider-covered person ratios by specialty; primary care professional-covered person ratios; geographic accessibility of providers; geographic variation and population dispersion; waiting times for appointments with participating providers; hours of operation; the ability of the network to meet the needs of covered persons (which may include low income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency); other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and the volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.[1]

Securing IRF access within network. Too often enrollees across the country are diverted into nursing homes rather than inpatient rehabilitation hospitals and units because plans do not contract with a sufficient number of these providers. Too often, enrollees with catastrophic injuries (e.g., traumatic brain injuries, strokes, spinal cord injuries) do not receive the intensive longer-term services they need because health plans do not contract with programs that specialize in treating such injuries. And too often, suppliers without sufficient training, expertise or credentials are called upon to provide highly complex prosthetic limb care or other specialized services and devices.

Too often we hear from QHP enrollees located within a few miles of a rehabilitation hospital that although the enrollees' physicians find the enrollee meets the medical necessity criteria for admission to an IRF, the enrollees' QHP network lacks any IRFs or they are too far from the patient's home. Consequently, enrollees of these QHPs must pay higher out-of-network fees to attain necessary inpatient rehabilitation. IRFs are a distinct post-acute care setting that must conform to unique heightened regulatory requirements while providing intensive hospital-level care. Supplementing CMS's proposed metrics for assessing the adequacy of a QHP's provider network with these additional data elements will afford more QHP enrollees timely access to necessary quality inpatient rehabilitation services.

Securing broad range of providers and access to specialized rehabilitation services. CPR urges CMS to adopt a network adequacy standard that requires health plans to have a full range of 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, and those that provide specialized rehabilitation services specifically, without additional cost-sharing burden to consumers. In addition to many of the specific types of services already mentioned, these services include: programs that specialize in treatment of traumatic brain injuries, strokes and spinal cord injuries, as well as chronic, disabling conditions like multiple sclerosis, including residential/transitional programs, prosthetists, orthotists, durable medical equipment (DME) providers, therapies, habilitation, 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 persons 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.

CPR believes 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. CPR supports 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 at least 90 days, even if those providers are not in their new plan's network.

Credentialing. CPR believes that all providers within networks must be appropriately certified and licensed by the appropriate bodies. Private accreditation from accreditation agencies who understand rehabilitation 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 provider networks.

Continuous Coverage

CPR understands from the language of the Proposed Rule that CMS is interested in promoting continuous coverage in any reform of the ACA. While CPR also supports continuous coverage, it opposes continuous coverage provisions that would link pre-existing condition exclusions to a continuous coverage requirement. Under such a requirement, individuals with rehabilitation needs who miss enrollment deadlines and/or are uninsured for a period of time could face medical underwriting which would make coverage unaffordable for those individuals.

Open and Special Enrollment

In the proposed rule, CMS will tighten up open and special enrollment periods. CPR believes that this could decrease access for patients needing rehabilitation services and devices, as the window of time to select coverage decreases. In addition, shorter enrollment periods may negatively affect the risk pool, as less costly "young invincibles" would have less time to sign up for coverage. CPR opposes any truncation of open and special enrollment that would decrease coverage for rehabilitation. Any revision to open and special enrollment periods should take into account the needs of those needing rehabilitation.

Rehabilitation Services and Devices

While the Proposed Rule does not address essential health benefits (EHBs), CPR would like to take this opportunity to ask CMS to preserve the definition of rehabilitation services and devices in the market stabilization final rule. The ACA created in statute the Essential Health Benefits (EHB) category of "rehabilitative and habilitative services and devices." ACA, Section 1302 (b). In the February 2015 Benefit and Payment Parameters Final Rule, the Centers for Medicare and Medicaid Services (CMS) defined "rehabilitation services and devices" using the definition of "rehabilitation

services" from the National Association of Insurance Commissioners' *Glossary of Health Coverage and Medical Terms* [1] plus explicitly adding rehabilitation devices, as follows:

> "Rehabilitation services and devices—Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition."[2]

This definition is a floor for individual insurance plans sold under the ACA exchanges. It was also adopted by states that chose to expand their Medicaid programs. For the first time, this definition established a uniform, understandable federal definition of rehabilitation services and devices that became a standard for national insurance coverage. We stress that this definition is a floor for coverage and includes both rehabilitative *services* and rehabilitative *devices*. The services and devices covered by the rehabilitation benefit should not be limited to the therapies enumerated in the federal regulation which are listed as *examples* of covered benefits.

We understand that an element of the legislation that House Republicans are considering would have states determine their respective essential health benefits package beginning on January 1, 2020. CPR supports the preservation of the EHB category of "rehabilitative and habilitative services and devices," and the subsequent regulatory definition and related interpretations duly promulgated, as a standard of coverage for rehabilitation under any version of ACA replacement legislation. CPR believes that adopting the uniform federal definition of rehabilitation services and devices minimizes the variability in benefits across states and uncertainty in coverage for children and adults in need of rehabilitation.

In addition to the regulatory definition cited above, examples of these types of services typically provided under this benefit include rehabilitation medicine, behavioral health services, recreational therapy, developmental pediatrics, cardiac and pulmonary rehabilitation, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings. These services should be provided based on the individual's needs, prescribed in consultation with a clinician, and based on the assessment of an interdisciplinary team and resulting care plan.

Rehabilitation Vignettes
The vignettes below help to demonstrate the value of rehabilitation:

<u>Rehabilitation Following a Severe Traumatic Brain Injury</u>
Jason was a 43-year-old computer systems administrator. Following a bicycle accident in April 2014, Jason was diagnosed with a severe traumatic brain injury. With intensive rehabilitation, he was able to overcome loss of motor skills, speech and memory. He is now able to care for his ten children, drive, and return to work.

<u>Rehabilitation Following Spinal Cord Injury</u>
Cayden is a 15-year-old high school student. Following a car accident in January 2016, he was diagnosed with a spinal cord injury causing paralysis in his arms and legs. With intensive rehabilitation, he was able to overcome significant deficits in balance and arm/hand function. He is now able to walk unassisted and drive, and has returned to school.

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[1] https://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf.
[2] http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf, at 10811.

Lisa is a 58-year-old elementary school teacher. Following a horseback riding accident in October 2013, Lisa was diagnosed with a two-level spinal cord injury causing paralysis in upper and lower extremities. With intensive rehabilitation, she was able to overcome dependence on a wheelchair, support at home, and significant deficit in left leg function. She is now able to live independently and can walk with a quad cane. Intensive rehabilitation continues to build strength and endurance.

Rehabilitation Following a Stroke

David is a 54-year-old man who suffered a cerebrovascular accident, or stroke, that resulted in cognitive deficits, including impaired attention and memory, executive function deficits, and social pragmatic communication deficits. Acquired brain injury—whether from traumatic brain injury, stroke, or brain disease—impacts a person's ability to function at work and at home, which is the case for David. A speech-language pathologist (SLP) evaluated David's speech, language and cognitive abilities using standardized testing to determine how his deficits affect his cognitive function and job performance. A plan of care was established to improve and maximize David's cognitive functioning, with the goal of returning him to his previous job, though with modified duties. Interdisciplinary collaboration ensures that David's multiple needs are met and coordinated among providers, including the psychologist and physician. The SLP focuses treatment on using existing cognitive strengths to implement compensatory strategies that address deficit areas.

Ed is a 50-year old high school volleyball and basketball coach. In September 2013, two strokes left him with a paralyzed left arm and leg. With intensive rehabilitation, he was able to overcome dependence on a wheelchair, and significant deficits in balance, leg and arm function. He is now able to walk unassisted and dance, and has returned to coaching.

Rehabilitation for Patients with Multiple Sclerosis

Joan is a 38 year-old accountant who was diagnosed with multiple sclerosis (MS) when she was 33. She has experienced relapses about every few months since then, with slowly advancing disability. While she is able to walk with a cane, she experiences painful flexor spasms which make it difficult for her to concentrate. In addition she experiences severe fatigue that peaks around mid-afternoon. Because of these symptoms she was seriously considering retiring on disability. Six months ago, she began regular sessions with a physical therapist (PT). Her PT taught her stretching exercises which have reduced her spasms. In addition, the PT worked with her to implement energy management strategies that have helped her fatigue. As a result, she is no longer thinking about retiring and is able to put in a full and productive work day.

Conclusion

Each of these vignettes represent real-life instances where access to rehabilitation services and devices has maximized the health, function, and independence of those who have been able to access these services. The undersigned members of CPR firmly believe that failing to preserve access to rehabilitative services and devices in any health reform would turn back the clock on children and adults with disabilities and chronic, progressive conditions.

Thank you for your consideration of our comments to this Proposed Rule. Should you have further questions regarding this information, please contact Peter Thomas or Steve Postal, CPR staff, by emailing Peter.Thomas@powerslaw.com or Steve.Postal@powerslaw.com, or by calling 202-466-6550.

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Sincerely,

CPR Steering Committee

Judith Stein	Center for Medicare Advocacy	JStein@medicareadvocacy.org
Alexandra Bennewith	United Spinal Association	ABennewith@unitedspinal.org
Kim Calder	National Multiple Sclerosis Society	Kim.Calder@nmss.org
Amy Colberg	Brain Injury Association of America	AColberg@biausa.org
Maggie Goldberg	Christopher and Dana Reeve Foundation	MGoldberg@ChristopherReeve.org
Sam Porritt	Falling Forward Foundation	fallingforwardfoundation@gmail.com

[1] See *Health Benefit Plan Network Access and Adequacy Model Act*, page 7. Accessible at: http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_revised_draft_proposed_revisions_mcpna_model_act.pdf.