November 27, 2017

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9930-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 2019 (RIN 0938-AT12)

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the proposed rule *HHS Notice of Benefit and Payment Parameters for 2019*[1] (the Proposed Rule). 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.

The Proposed Rule sets forth benefit and payment parameters, provisions related to essential health benefits (EHBs), qualified health plans (QHPs), risk adjustment, and the operation of Federally-facilitated exchanges (FFEs) and State-based exchanges (SBEs), as well as many other policies implementing the Affordable Care Act (ACA). This comment letter will focus on key proposed provisions that relate to enrollees in need of medical rehabilitation and post-acute care, specifically rules related to the essential health benefit category of rehabilitation and habilitation services and devices, as well as provider network adequacy requirements.

I. The Importance of Rehabilitative Services and Devices

Rehabilitation services are provided to help a person regain, maintain, or prevent deterioration of a skill, condition, or function that has been acquired but then lost or impaired due to illness,

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51,052 (Nov. 2, 2017). Available at: https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf.

injury, or disabling condition. Rehabilitation services are essential to enable people with injuries, illnesses, and disabilities to:

- Improve, maintain, or slow deterioration of health status;
- Improve, maintain, or slow deterioration of functional abilities;
- Live as independently as possible;
- Return to work, family, and community activities as much as possible;
- Avoid unnecessary and expensive re-hospitalization and nursing home placement; and
- Prevent secondary medical conditions.

Rehabilitation services are closely related to habilitation services, which focus on skills, conditions, and functions that were never acquired. Rehabilitative and habilitative services and devices include but are not limited to rehabilitation medicine, inpatient rehabilitation hospital care, physical and occupational therapy, speech language pathology services, behavioral health services, recreational therapy, developmental pediatrics, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings.

The following vignettes demonstrate just a few examples of 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:

- *Rehabilitation Following a Traumatic Brain Injury*. Jason is a 43-year-old computer systems administrator. Following a bicycle accident in April 2014, Jason was diagnosed with a traumatic brain injury. Through an intensive team-based rehabilitation process, he was able to transition from total loss of motor skills, speech, and memory, resuming full function in his previous roles. He is now able to care for his three children, drive, and return to work.

- *Rehabilitation Following a Spinal Cord Injury.* 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 from a multidisciplinary team of medical professionals, including physical and occupational therapists, he was able to regain balance and arm/hand function. He is now able to walk unassisted and drive, and has returned to school.

- *Rehabilitation Following a Stroke.* 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 no longer uses on a wheelchair and has improved his balance, leg, and arm function. He is now able to walk unassisted and dance, and has returned to coaching.

There is a compelling case for coverage of both rehabilitative and habilitative services and devices for persons in need of functional improvement due to disabling conditions. These services and devices are designed to maximize the functional capacity of the individual, which has profound implications on the ability to perform activities of daily living in the most independent manner possible. Both rehabilitative and habilitative services and devices are

highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

II. Background on Rehabilitative Services and Devices under the ACA

The Affordable Care Act includes statutory language that requires coverage of essential health benefits, including one of ten categories of benefits known as "rehabilitative and habilitative services and devices." Inclusion of this language in the statute was a major milestone for the rehabilitation and disability community in that Congress recognized the importance of these benefits to improve the health and functioning of the American people.

In the February 2015 Notice of Benefit and Payment Parameters Final Rule,[2] the Centers for Medicare and Medicaid Services (CMS) defined "rehabilitation services and 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."

For the first time, this regulation established a uniform definition of rehabilitation services and devices that states could understand and consistently implement. This definition became a standard for private insurance coverage, a floor of coverage for individual insurance plans sold on the exchanges. Importantly, the definition includes both rehabilitative *services* and rehabilitative *devices*. The adoption of a federal definition of rehabilitation services and devices minimized the variability in benefits across States and the uncertainty in coverage for children and adults in need of medical rehabilitation and post-acute care.

III. Essential Health Benefits

The proposed rule seeks to grant states additional flexibility to tailor their benchmark benefit coverage to attempt to lower costs and, thereby, expand insurance options for consumers. While expanded coverage options and lower health care costs are two important goals, we urge the final rule to balance these goals against the statutory requirements for EHB coverage, as well as the nondiscrimination provisions of the ACA. Adhering to these statutory requirements of the ACA will decrease the likelihood that additional flexibility will lead to the emergence of bare-bones benefit packages, particularly in the area of rehabilitation. CPR has specific concerns, outlined below, about each of CMS's proposals to grant states additional flexibility and discretion in designing their EHB benchmark plans, including CMS's revised definition of a "typical employer plan."

In the Proposed Rule, CMS states that, starting in plan year 2019, States would be permitted to change their EHB benchmark plan annually by:

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,811 (Feb. 27, 2015).

- Selecting the EHB-benchmark plan that another State used for the 2017 plan year under § 156.100 and § 156.110;

- Replacing one or more EHB categories of benefits under § 156.110(a) in its EHB benchmark plan used for the 2017 plan year with the same categories of benefits from another State's EHB-benchmark plan used for the 2017 plan year under § 156.100 and § 156.110; or,

- Otherwise selecting a set of benefits that would become the State's EHB benchmark plan, provided that the EHB benchmark plan does not exceed the generosity of the most generous of among a set of comparison plans.

CMS further states that, under this proposal, a state's EHB benchmark plan must be equal in scope to the benefits provided under a "typical employer plan." This requirement reflects the statutory requirement in the ACA that the scope of EHBs must be equal to the scope of benefits provided under a typical employer plan. In the proposed rule, CMS proposes to revise the definition of a "typical employer plan" as "an employer plan within a product (as these terms are defined in § 144.103 of this subchapter) with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more States, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more States."

Specific Concerns Regarding Each EHB Benchmark Plan Design Option in the Proposed Rule

CPR is concerned that the additional options available to states to redefine their benchmark benefits coverage may create a "race to the bottom" in the scope of coverage available to consumers in the various states. Rehabilitation services and devices are simply too important to those in need of medical rehabilitation and post-acute care to allow States to substantially limit these benefits in redefining new EHB benchmark plans. These benefits must be available to individuals when they truly need them. Access to rehabilitation benefits can save significant health care dollars in the long term and reduce the need for more intensive health care services later in life.

Specifically with respect to the first and second proposed options that would allow States to substitute either their entire EHB benchmark plan with the plan of another State or would allow States to replace one or more EHB categories of benefits with that of another State, CPR is deeply concerned that States will exercise this option to select a more limited rehabilitation benefits package than they currently offer. As discussed below, this is contrary to quality of care and cost-saving principles.

With respect to the third option, which would essentially allow States to rewrite their own benchmark plans while imposing a limit on the benchmark plan's generosity, CPR is concerned that this will contribute to a significant decrease in coverage of EHBs, particularly rehabilitative services and devices. By granting States expansive power to alter their EHB benchmark plans so dramatically every year, the Proposed Rule threatens any hope of predictability of coverage for consumers from year-to-year and State-to-State. This will likely reduce quality of care and

increase downstream costs due to a lack of predictability in coverage of these essential services and devices.

Furthermore, CMS's proposed definition of a "typical employer plan" would considerably weaken EHBs and allow states to search out the most sparing plans in the nation. As a result of the lack of constraints placed on what constitutes a "typical employer plan," these plans would hardly be "typical" and CMS's proposed definition would allow states to disregard the differences in health care needs between the populations of different states in establishing their benchmark plans. The CPR supports CMS's suggestion that the definition of typical employer plans should be limited to plans that already cover all 10 EHB categories. Furthermore, a typical employer plan should have to be from a recent year, as well as be required to meet minimum value standards or not be an indemnity plan or a health reimbursement arrangement.

Congressional Intent and Statutory Requirements for EHB Coverage

Rehabilitative and habilitative services and devices are mandated as EHBs in Section 1302 of the ACA. It is critical that the final regulations on EHB benchmark plans explicitly establish appropriate coverage of these benefits in a manner that is consistent with the statute and the needs of adults and children that require rehabilitation services and devices. The legal parameters in the ACA statute discussed above and the explicit statutory mandate to cover rehabilitative services and devices while ensuring that benefit design not be discriminatory based on disability are important guardrails the final rule must respect.

We believe an EHB regulation that does not ensure appropriate coverage of rehabilitative services and devices for the segment of the population that needs access to these services would be in conflict with the letter and the spirit of the law. These legal parameters also mean that people with disabilities and chronic conditions who need rehabilitative and habilitative services and devices should not face unreasonably restrictive coverage policies or arbitrary constraints that hinder their ability to achieve results through appropriate treatment.

CPR supports the preservation of the statutory interpretation and the federal regulations defining the EHB category of "rehabilitative and habilitative services and devices." To help ensure appropriate coverage, we urge CMS to reemphasize in the final rule the following requirements and principles to the States with regard to EHB benchmark plan design:

- The ACA's EHB package was intended to meet the needs of individuals requiring rehabilitative and habilitative services and devices, and specifically included language in the law to this effect.
- Limitations in benefits of any kind should be based on the best available evidence and such decisions should be made by professionals with sufficient knowledge and expertise in the rehabilitative and habilitative fields to render informed decisions.
- The uniform definition of rehabilitative *services* and *devices* serves as a minimum standard for covering rehabilitative benefits. These benefits should not be limited to the therapies enumerated in the federal regulation, which are merely listed as examples of covered benefits.

- Rehabilitative and habilitative services and devices should be covered without arbitrary restrictions and caps that limit the effectiveness of the benefit and undercut the purpose of the ACA's prohibition on lifetime and annual limits in benefits. 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 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 monetary caps in coverage of durable medical equipment, prosthetics, orthotics, and other devices is expressly prohibited. Arbitrary limitations and exclusions of certain devices from an EHB benchmark plan may constitute discriminatory plan design and should not be permitted.
- Benefits cannot be defined in such a way as to exclude coverage for services based upon age, disability, or expected length of life—an explicit requirement included in the ACA.

Antidiscrimination Provisions of the ACA

We encourage CMS to preserve a federal role for monitoring whether States comply with the key antidiscrimination portions of the ACA to ensure that health plan benefit designs do not discriminate. The ACA requires that benefit design not discriminate against individuals because of their age or disability.[3] There are numerous legal protections in the ACA that are designed to ensure fairness and equity in the benefit design of the EHB package. These provisions include the prohibition against discrimination based on health status or disability[4], as well as the general nondiscrimination section of the law found at Section 1557 of the ACA. These provisions also include the requirement that the Secretary must ensure that essential benefits reflect an "appropriate balance" of benefits covered across categories[5], that there is parity across the categories of benefits[6], and that the Secretary must not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of disability.[7]

Further, the Secretary must take into account the health care needs of diverse segments of the population, including children, persons with disabilities, and other groups.[8] This language speaks directly to the need to include in the EHB package services and devices such as rehabilitation. In addition, the Secretary must ensure that EHBs are not subject to denial to individuals against their wishes on the basis of the individual's present or predicted disability, degree of medical dependency, or quality of life.[9] CPR urges CMS to reiterate these requirements in the final rule so that states are clear that they must continue to meet these protections when designing EHB benchmark plans.

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(4)(B) (2010).
[4] *Id.* § 1201.
[5] *Id.* § 1302(b)(4)(A).
[6] *Id.*
[7] *See id.* § 1302(b)(4)(B).
[8] *See id.* § 1302(b)(4)(C).
[9] *See id.* § 1302(b)(4)(D).

Impact on Health Care Costs

A reduction in coverage under EHBs is not likely to significantly reduce health care costs.[10] This is particularly true for coverage of habilitative and rehabilitative care, which accounts for just 2% of total premium dollars. Reducing coverage of these services would not significantly decrease the cost of insurance packages overall, but would lead to very high increases in out-of-pocket costs for children, families, and adults who need this type of care. In addition, limiting access to health care for people with disabilities or chronic conditions is not cost-effective in the long term as it often results in further complications and avoidable hospital admissions and readmissions.

CPR shares CMS's goal of reducing the costs of health care and promoting competition in the marketplace. However, CPR believes that the federal government must play a strong role in the enforcement of the EHB package, particularly when certain EHB benefits, such as rehabilitative and habilitative services and devices, are subject to burdensome and discriminatory practices and standards. As discussed in this comment letter, both rehabilitation and habilitation services and devices are highly cost-effective and decrease downstream costs to the health care system and society at large for unnecessary disability and dependency. For these reasons, it is essential that any regulatory changes that states make under the final rule maintain access to the full continuum of rehabilitation care.

IV. Network Adequacy

The adequacy of a plan's provider network can impact the level of access to benefits for enrollees. CPR has concerns, outlined below, about network adequacy under CMS's proposal to grant the states a larger role in the QHP certification process. CPR urges CMS to ensure that, if states are given a larger role in the QHP certification process, state review processes are sufficient to ensure that network adequacy standards safeguard access to a range of physically accessible, qualified providers across primary care, specialties, and subspecialties, without the burdens of significant travel distances and long waiting times. In addition, CMS must ensure that these standards are enforceable.

Under the Proposed Rule, states would have a larger role in the QHP certification process. CMS proposes that, starting in plan year 2019, the FFEs and SBEs on the Federal platform (SBE-FPs) rely on State reviews of network adequacy standards where the States have been determined to have an adequate review process. CMS also proposes to eliminate requirements for SBE-FPs to enforce FFE standards for network adequacy (42 C.F.R. § 156.230). Instead, SBE-FPs would have the flexibility to determine how to implement the network adequacy standards with which issuers must comply.

For QHP enrollees to benefit from appropriate rehabilitation, we believe that QHPs sold through the 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,

[10] Linda J. Blumberg & John Holahan, *The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums Under the ACA*, Robert Wood Johnson Foundation (July 2017), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf438507.

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 team and resulting 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-language 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 or 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. CPR supports maintaining and strengthening federal network adequacy standards, and is concerned that a reduced federal role in reviewing network adequacy would only exacerbate this problem. In determining whether a State has an adequate review process for network adequacy standards and whether a State can enforce network adequacy standards in their State, CPR urges CMS to look to whether the State has adopted the following metrics for assessing a QHP's network adequacy:

- *Broad application of time and distance standards.* 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. Any assessment of network breadth should be broad enough to account for the medical needs of QHP enrollees residing in rural areas. 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 provider networks help ensure access to appropriate rehabilitation, including access to in-network inpatient rehabilitation hospitals (IRFs).* A wide range of rehabilitation 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 IRFs 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 treatment programs. Often we hear from QHP enrollees located within a few miles of a rehabilitation hospital that although the enrollees' physicians find the enrollee meets 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 must pay higher out-of-network fees to attain necessary inpatient rehabilitation. Taking these data elements into account when assessing adequacy of a QHP's provider network will help ensure that enrollees have timely access to necessary care.

- *Securing a broad range of providers and access to specialized rehabilitation services.* Network adequacy standards must require 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 services and devices specifically, without additional cost-sharing burden to consumers. In addition to many of the specific types of services already mentioned, these services include: brain injury treatment programs including residential/transitional programs, prosthetists, orthotists, durable medical equipment providers, 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.

- *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.* We believe that all providers within networks must be appropriately certified and/or licensed by the appropriate bodies. For example, too often suppliers without sufficient training, expertise, or credentials are called upon to provide highly complex prosthetic limb care or other specialized rehabilitative services and devices that appropriately credentialed providers should be providing. Private accreditation from accreditation agencies that understand rehabilitation is a good indicator of quality providers.

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 the QHP in which they are enrolled. We believe 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. Additionally, network adequacy standards should ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under a plan. In light of these concerns, review processes must ensure robust network adequacy standards and these standards must be strongly enforced. It is essential that Americans have access to affordable and meaningful coverage of rehabilitative services and devices through the private market.

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Access to rehabilitative and habilitative services and devices is essential for the health and livelihood of people with disabilities and others in need of medical rehabilitation and post-acute care. These services also are critical for reducing downstream costs to the health care system for unnecessary disability and dependency. In order for these services and devices to be accessible, EHB benchmark plans must include coverage of a robust benefit package of rehabilitative and habilitative services and devices, in accordance with the statutory language and intent of the ACA. In addition, these covered services must be accessible through a range of providers across primary care, specialties, and subspecialties, without the burdens of significant travel distances and long waiting times.

CPR urges CMS to preserve access to rehabilitative and habilitative services and devices in the Final Rule in order to reduce costs to the health care system and ensure that children and adults can maximize their health and independence through access to these services.

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 Leif Brierley, coordinators for CPR by e-mailing Peter.Thomas@PowersLaw.com or Leif.Brierley@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation
Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
Association of University Centers on Disabilities
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Epilepsy Foundation
Falling Forward Foundation
(continued on next page)

Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Athletic Trainers' Association
National Disability Institute
National Multiple Sclerosis Society
Paralyzed Veterans of America
Rehabilitation Engineering and Assistive Technology Society of North America
The Arc of the United States
Uniform Data System for Medical Rehabilitation
United Spinal Association