



December 21, 2015

**VIA ELECTRONIC SUBMISSION**

Andrew Slavitt  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9937-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: Public Comments on HHS Notice of Benefit and Payment Parameters for 2017 (RIN 0938-AS57)**

Dear Administrator Slavitt:

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 2017*<sup>1</sup> (the Proposed Rule). CPR is a coalition of national consumer, clinician, and membership organizations that advocates for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions can regain and/or maintain their maximum level of health and independent function.

The Proposed Rule establishes additional regulations on a variety of private insurance provisions applicable to ACA plans, including risk adjustment, cost-sharing and user fees for Federally-facilitated Exchanges (FFE), standards for the 2017 individual market open enrollment period, essential health benefits, qualified health plans, network adequacy, patient safety standards, the medical loss ratio program, and other related topics.

This comment letter will focus on key proposed provisions that relate to post-acute care and rehabilitation patients, including network adequacy, cost-sharing, patient safety standards for issuers of Qualified Health Plans (QHPs), and risk adjustment. While we noticed that the Proposed Rule applies to FFEs, we request that the Rule, once finalized, make clear that it applies to all Exchanges, including state-based Exchanges. Hereafter in this comment letter, all references to FFEs and state-based Exchanges will be collectively referred to as “Exchanges.”

For QHP enrollees to benefit from skilled rehabilitation care, CPR believes that QHPs sold through Exchanges must adhere to patient-friendly network adequacy standards that provide ample access to the full complement of rehabilitation services and devices, and the health care professionals and facilities that provide them. 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 team and resulting care plan.

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. It includes post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs), skilled nursing, home health, and home and community based services. It also includes 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, 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, if not restricted, access to many of these types of providers. Our comments below provide suggestions to remedy that situation.

### **I. Essential Health Benefits**

CPR appreciates CMS' clarification in last year's proposed rule of the rehabilitative and habilitative services and devices category of essential health benefits (EHBs). For instance, under the February 2015 final rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016* (the Rule), every state's EHB plan must:

- **Adopt the Rule's definition of rehabilitative (and habilitative) services and devices as the floor for individual and small employer health insurance plans beginning in 2016.** The CPR Coalition believes that adopting the uniform federal definition of rehabilitation services and devices minimizes the variability in benefits and uncertainty involving the rehabilitation benefit. The federal definition appears in the preamble of the Rule 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.” See §156.115(a)(5), page 10811 of [The Rule](#).

We stress that this definition is a floor for coverage and includes both rehabilitative *services* and rehabilitative *devices* that may be required to meet this standard. The services and devices covered by the rehabilitation benefit should not be limited to certain specific therapies but include a wide array of rehabilitation therapies and devices.

- Not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and,
- For plan years beginning on or after January 1, 2017, not impose combined limits on habilitative and rehabilitative services and devices.<sup>1</sup>

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<sup>1</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10871 (February 27, 2015).

Caps on rehabilitative and habilitative services and devices. CPR was hoping that CMS would elaborate on this benefit category in this year's proposed rule, but it said little about this issue, despite the fact that most QHP's have instituted arbitrary caps in certain rehabilitative and habilitative health benefits, such as one-size-fits-all outpatient therapy caps. CPR requests CMS to include in the final rule an admonition to QHPs that these types of arbitrary caps in rehabilitation benefits 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. CPR believes 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.

Examples of discriminatory caps, and discriminatory QHP EHB designs more broadly, include plan provisions that:

- Place limits on the number of therapy visits a QHP enrollee can access regardless of whether the enrollee meets medical necessity criteria;
- Apply a benefit exclusion for certain types of modern prosthetic limb to only one disability group, individuals with limb loss; and,
- Fail to cover brain injury services in their EHB when the enrollee's brain injury is related to a suicide attempt.

## **II. Proposed Metrics for Assessing a Qualified Health Plan's Network Adequacy**

CPR supports the following two metrics CMS anticipates requiring of its Exchange QHP issuers to assess their compliance with Exchange network adequacy standards:

- Prospective time and distance standards at least as strong as the FFE standard; and
- Prospective minimum provider-covered person ratios for specialties with the highest utilization rates in the given State.

However, CPR believes that these alone are insufficient. In addition to having these metrics also apply to state-based Exchanges, CPR would supplement the above with additional metrics, including:

Broader application of time and distance standards. First, CPR believes that the definition of a geographic area giving rise to 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.<sup>2</sup>

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 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 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: brain injury treatment programs 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 up to 90 days, even if those providers are not in their new plan's network. Certainly, patients in the midst of 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 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 also allow patients to find and make 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.

Waiting times. CMS seeks comments on proposals adding a state-based standardized waiting time for scheduled appointments as an option, or if a broader standard for waiting times should be applied across QHPs in the FFEs.<sup>3</sup> CPR proposes that all QHPs in Exchanges must be required to report to CMS average waiting times for appointments with providers, and establish a system to field complaints of provider access from plan enrollees. CMS should also hold plans accountable when their provider networks are too narrow to meet patient needs, and ensure that plans are delivering the benefits they contracted to provide.

Transparency regarding accepting new patients. CMS seeks comments on proposals requiring issuers to regularly survey all contracted providers to determine if a sufficient number of providers are accepting new patients.<sup>4</sup> CPR supports such a regular survey in order to provide consumers of rehabilitation services with the most information possible about available care. CPR believes that QHPs should be required to submit the names and specialties of network providers who are accepting new patients. A recent Government Accountability Office (GAO) study on Medicare Advantage managed care organization plans' compliance with network adequacy standards found that almost half of the providers listed within Medicare Advantage plans' provider directories have ceased to accept new patients.<sup>5</sup> To protect against a similar result becoming characteristic of QHPs, CMS should require QHPs to share the names and specialties of rehabilitation providers within their networks who currently accept new patients.

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.

### **III. Proposed Qualified Health Plan Network Adequacy Rating**

CPR endorses CMS’s proposal to provide a rating of each QHP’s relative network coverage on HealthCare.gov, as it provides beneficiaries greater knowledge into the quality of these networks, and provides greater accountability to QHPs. That said, CPR further suggests the following:

“Same geographic area.” While CPR supports CMS’s proposal to design a QHP’s network adequacy rating so that it is a comparison of the breadth of the QHP provider network at the plan level and the breadth of other QHP provider networks within the same geographic area, CPR recommends that CMS define the phrase “same geographic area” broadly enough so as to account for the remoteness of certain rehabilitation providers in more rural areas.

Timely and prominent publication. For CMS’s proposed QHP network adequacy rating to have its intended effect of informing enrollees of the actual health care providers that they can timely access, CPR recommends that CMS’s calculation of individual QHPs’ network adequacy rating be completed, as well as published, before open enrollment for prospective QHP enrollees commences. 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.

Additionally, we make the following specific recommendations:

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

### **IV. Out-of-Network Cost-Sharing (Section 156.230(f))**

In the Proposed Rule, each QHP must either: 1) count cost-sharing paid by an enrollee for an EHB service provided by an out-of-network provider in an in-network setting toward the enrollee’s annual limitation on cost sharing, or 2) provide a written notice to the enrollee at least 10 business days before the service is to be provided, alerting the enrollee to possible added costs, including balance billing charges, incurred for such a situation and that such charges may not count toward the in-network annual cost sharing limit.<sup>6</sup>

CPR believes that out-of-network arrangements, such as single-case agreements, should be used only as an exception for extremely rare services. However, 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 example, cost-sharing and other requirements for the receipt of out-of-network care should follow the same protections set forth by the plan as if the care was contracted as in-network. 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 recommend that §156.230(e)(2) be revised to make it clear that consumer cost-sharing paid to a provider under this provision also counts 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 partway through their plan year, when they have no ability to switch to a different plan.

Customized information to consumers. CMS seeks comments as to whether it should require issuers to send customized information to the consumer regarding information on potential in-network providers.<sup>7</sup> CPR supports this in order to provide consumers of rehabilitation services with the most information possible about available care.

Suggested revisions. We make the following recommendations for improving §156.230(f):

- Revise (f)(1) to read: “(1) Count amounts paid by an enrollee, ***including balance billed amounts***, for an essential health benefit provided by an out-of-network provider at an in-network setting towards the enrollee’s annual limitation on cost sharing, ***even if the plan does not otherwise include an out-of-network benefit***,” and
- Revise (f)(2) to read: “(2) Provide a written notice to the enrollee at least ten business days before the provision of the benefit that additional costs may be incurred for an essential health benefit provided by an out-of-network provider in an in-network setting, ~~including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not could toward the in-network annual limitation on cost sharing.~~ ***and including a good faith estimate of the projected amounts for which the covered person may be responsible, up to the enrollee’s annual limitation on cost sharing, and a list of in-network providers at the facility where care is being authorized.***”
- Add a provision protecting consumers from balance billed amounts provided in an emergency in an out-of-network setting.

NAIC Network Adequacy Model Act. CPR also proposes that CMS add language suggested by the NAIC Network Adequacy Act to be inserted at the end of proposed rule 156.230(f)<sup>8</sup> to state the following:

(3) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider when:

- (a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and
- (b) The health carrier:
  - (i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

- (ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(For purposes of this paragraph, “specialized health care services or medical services” include the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.)

## V. Risk Adjustment

CPR recognizes 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, CPR stresses 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 standard), thus increasing the chances of stinting on patient care to those who need it most.

## VI. Standardized Options (Section 156.20)

In the Proposed Rule, CMS states that it is proposing “standardized options” in the individual market FFEs to simplify the consumer plan selection process.<sup>9</sup> However, in Table 9-Proposed 2017 Standardized Options, CMS lists “Rehabilitative Speech Therapy” and “Rehabilitative OT/PT” but not habilitative services, indicating that rehabilitative services are subject to a coinsurance but habilitative services are not.<sup>10</sup> CPR requests clarification on this point, and suggests that both rehabilitative and habilitative services and devices in the Exchanges be exempt from co-insurance. We request:

- this exemption based on the understanding that habitation and rehabilitation are to be treated the same;
- that rehabilitative OT and PT be considered separate and distinct therapy services, similarly to how rehabilitative speech therapy is listed separately; and,
- that cost-sharing be reasonable in order to not be a barrier to consumers accessing necessary therapy services.

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We greatly appreciate your attention to our concerns and your interest in our participation in this process. Should you have further questions regarding this information, please contact Peter Thomas or Steven Postal, CPR Coordinators, by emailing [Peter.Thomas@ppsv.com](mailto:Peter.Thomas@ppsv.com) or [Steven.Postal@ppsv.com](mailto:Steven.Postal@ppsv.com), or by calling 202-466-6550.

Sincerely,

### CPR Steering Committee

Judith Stein (Center for Medicare Advocacy)  
Alexandra Bennewith (United Spinal Association)  
Kim Calder (National Multiple Sclerosis Society)  
Amy Colberg (Brain Injury Association of America)  
Rachel Patterson (Christopher and Dana Reeve Foundation)  
Sam Porritt (Falling Forward Foundation)

[JStein@medicareadvocacy.org](mailto:JStein@medicareadvocacy.org)  
[ABennewith@unitedspinal.org](mailto:ABennewith@unitedspinal.org)  
[Kim.Calder@nmss.org](mailto:Kim.Calder@nmss.org)  
[AColberg@biausa.org](mailto:AColberg@biausa.org)  
[rpatterson@ChristopherReeve.org](mailto:rpatterson@ChristopherReeve.org)  
[fallingforwardfoundation@gmail.com](mailto:fallingforwardfoundation@gmail.com)



## **Supporting Organizations**

American Academy of Physical Medicine and Rehabilitation  
American Association on Health and Disability  
American Congress of Rehabilitation Medicine  
American Music Therapy Association  
American Physical Therapy Association  
American Therapeutic Recreation Association  
Amputee Coalition  
The Arc of the United States  
Association of University Centers on Disabilities  
Brain Injury Association of America  
Center for Medicare Advocacy  
Christopher and Dana Reeve Foundation  
Disability Rights Education and Defense Fund  
Easter Seals  
Falling Forward Foundation  
Lakeshore Foundation  
National Association for the Advancement of Orthotics and Prosthetics  
National Association of State Head Injury Administrators  
National Multiple Sclerosis Society  
Paralyzed Veterans of America  
Parkinson's Action Network  
United Spinal Association

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<sup>1</sup> *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017*; 80 Fed. Reg. 75,488 (December 2, 2015). Available at: <http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf>.

<sup>2</sup> 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\\_a ct.pdf](http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_revised_draft_proposed_revisions_mcpna_model_a ct.pdf).

<sup>3</sup> *Payment Parameters at 75552*.

<sup>4</sup> *Id.*

<sup>5</sup> See *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*, GAO-15-710 (August 31, 2015).

<sup>6</sup> *Payment Parameters at 75586*.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* at 75542.

<sup>10</sup> *Id.* at 75543-75544.