



December 22, 2014

Katherine Archuleta
Director
National Healthcare Operations, Healthcare and Insurance
U.S. Office of Personnel Management
1900 E Street N.W., Room 3468
Washington, D.C. 20415

RE: (RIN 3206-AN12) Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges

Dear Director Archuleta:

The undersigned members of the Coalition to Preserve Rehabilitation appreciate the opportunity to comment on the proposed rule *Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges*. The CPR believes the federal government must play a strong leading role in the establishment and enforcement of the Multi-State Plan Program and we strongly support the Office of Personnel Management's (OPM) efforts in that regard. 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.

Federal Regulation of the Definition of Habilitative Services

In its proposed rule, the Centers for Medicare and Medicaid Services (CMS) seeks to establish a uniform definition of habilitative services in a new section of its regulations at §156.155(a)(5)(i). CMS also solicits comments on whether it should define habilitative services as detailed in the proposed rule, maintain its current policy by largely deferring to the states and health plans to define such benefits, or permit the use of other more specified definitions. OPM, in its proposed rule, offers to similarly change the regulations to apply a federal definition of habilitative services, should HHS choose to define the term.

States should adopt uniform definition: The CPR applauds OPM for seeking to establish a federal definition of habilitative services. We commend CMS for suggesting the adoption of the National

Association of Insurance Commissioners' (NAIC) definition¹ of habilitative services and we strongly support a requirement that all states adopt a minimum definition as articulated by the NAIC with the addition of "devices" to the definition as described below.

At the same time, we believe that OPM can and should go farther in specifying the scope and breadth of this important benefit which, currently, is poorly understood by health plan issuers.

Specific services and devices covered: The final rule should explicitly include greater specificity on the types of benefits typically included in the provision of habilitative services and devices.

OPM should include the following habilitative services in the final rule for illustrative purposes, but ensure that issuers do not consider this to be an exhaustive list:

"Habilitative services" means health care services *and devices* that are designed to assist individuals in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. These services may include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and other services and devices for people with disabilities in a variety of inpatient and/or outpatient settings. Plans should use Medicaid coverage as a guide where there is a question of whether to cover specific habilitation benefits.

Habilitative services should be provided based on the individual's needs, in consultation with a clinician, and based on an assessment by an interdisciplinary team and resulting care plan.

OPM should also provide a list of habilitative devices for illustrative purposes but make clear in the regulation that this is not an exhaustive list. For instance, "habilitative devices" typically include:

- ***Durable Medical Equipment (DME)*** including:
 - Equipment and supplies ordered by a health care professional for everyday or extended use to improve, maintain or prevent the deterioration of an individual's functional ability. Examples of DME include, but are not limited to, manual and electric wheelchairs, oxygen equipment, canes, crutches, walkers, standing system chairs, blood testing supplies for people with diabetes, as well as supplies and equipment to support medically necessary devices;
- ***Orthotics and Prosthetics*** including, but not limited to:
 - Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, and external breast prostheses incident to mastectomy resulting from breast cancer. Covered services include adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- ***Prosthetic Devices*** including:
 - Devices that replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of prosthetic devices include, but are not limited to joint replacements, colostomy care,

¹ See, NAIC Glossary of Terms for the Affordable Care Act. "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."

and implanted breast prostheses incident to mastectomy resulting from breast cancer, cochlear implants, and osseointegrated implants to replace middle ear or cochlear function. Covered services include maintenance, adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;

- **Low Vision Aids** including:
 - Devices that help correct for the partial loss of eyesight, making it possible for an individual with impaired vision to accomplish everyday tasks, including reading, writing, driving a car or recognizing faces. Examples of low vision aids include, but are not limited to, devices which magnify, reduce glare, add light or enlarge objects as to make them more visible;

- **Augmentative and Alternative Communication Devices (AACs)** including:
 - Specialized devices ordered by a health care professional which assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices; and

- **Hearing Aids and Assistive Listening Devices** including:
 - Medical devices which amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional.

Definition of Rehabilitative Services

The benefit category the proposed rule seeks to clarify involves both rehabilitative *and* habilitative services and devices. The CPR wishes to clarify that its recommendations with respect to *habilitative* services and devices equally apply to *rehabilitative* services and devices. For instance, the final rule should adopt a federal regulatory definition of “rehabilitative services” that includes explicit recognition of coverage of *devices* and serves as a floor for coverage by states and issuers in EHB benefit packages. The final rule should use the National Association of Insurance Commissioners’ (NAIC) definition² of rehabilitative services and we strongly support a requirement that all states adopt a minimum definition of this term with the addition of “devices,” much like the habilitative services definition.

However, we also believe that the agency can and should go farther in specifying the scope and breadth of this important benefit which is also poorly defined at the state level.

Specific services and devices covered: The final rule should explicitly include greater specificity on the types of benefits typically included in the provision of rehabilitative services and devices. CMS should include the following rehabilitative services in the final rule for illustrative purposes, but ensure that issuers do not consider this to be an exhaustive list:

² See, NAIC Glossary of Terms for the Affordable Care Act. “Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”

"Rehabilitative services" means health care services and devices that are designed to assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. These services include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitative "devices" are identical to habilitative devices as outlined earlier in this comment letter. In addition to those services listed in our recommended definitions of habilitative and rehabilitative services, many other types of services are typically provided under this benefit, including 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.

"Flexibility" and Minimum Standard of Coverage for Habilitation and Rehabilitation Services and Devices

With regard to OPM's proposal to offer flexibility in the selection of the package of benefits in order to "increase competition and consumer choice while maintaining benefit standards and protections," to best ensure consumer protections, the CPR recommends that OPM state in its final rule that in order to meet the minimum definition of habilitation and rehabilitation services and devices used by States and health plan issuers, a plan must:

- Cover rehabilitative and habilitative services and devices without arbitrary restrictions and caps that limit the effectiveness of the benefit and subvert the intent of the Affordable Care Act's prohibition on lifetime and annual limits in benefits;
- Cover habilitation separately and distinctly from rehabilitation with separate cost-sharing and visit limits, if applied. For example, the plan should not be able to substitute rehabilitation for habilitation or apply only a single visit limit to both benefits.³ If visit limits are applied to a benefit category, each benefit must have separate and distinct limits.
- Cover rehabilitative and habilitative services and devices in a manner that permits some flexibility in benefit design and administration to accommodate those who need additional therapy to achieve medically necessary, therapeutic goals;
- Not impose financial requirements (such as copayments or coinsurance) or quantitative treatment limitations (such as a limit on the number of outpatient visits or inpatient days covered) on rehabilitative or habilitative services and devices that are more restrictive than the predominant requirements or limitations that apply to all other benefit categories;

³ Numerous states appear to have base-benchmarks that apply a single, existing rehabilitation visit limit to both the rehabilitation and habilitation benefit. For the majority of states choosing this option, this has meant a 20-visit limit for PT and OT combined whether it is rehabilitation or habilitation. This so severely limits the availability of the therapies it would discourage enrollment by anyone in need of these medical services.

- Prohibit unreasonable and arbitrary visit and dollar limits on a specific category of benefits resulting in a condition-based exclusion or condition-based limits. For example, health plans should not set condition-specific medical device exclusions. In the same manner, plans should not place arbitrary limits on devices which prevent a patient from receiving the accepted and recognized standard of care appropriate for that benefit; and
- Prohibit defining the benefits in such a way as to exclude coverage for those services based upon age, disability or expected length of life, explicit requirements included in the Affordable Care Act.

Maintenance of Function: Additionally, consistent with the *Jimmo v. Sebelius* settlement agreement clarifying Medicare coverage for skilled rehabilitative services, the CPR recommends that OPM state in its final rule that in order to meet the minimum definition of habilitation and rehabilitation services and devices used by States and health plan issuers, a plan must cover benefits that promote the ***maintenance of function***, in addition to services provided that improve the functional status of the enrollee.⁴

“Maintenance of function” refers to maintenance coverage of habilitation and rehabilitation services and devices when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of these services and devices are necessary for the performance of a safe and effective maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration. This includes coverage of the design of a maintenance program by a qualified therapist, the instruction of the beneficiary regarding the maintenance program, and necessary periodic reevaluations by a qualified therapist, assuming that specialized knowledge and judgment of a qualified therapist are required.

Exceptions Process: Typical rehabilitative and habilitative benefit packages often limit the number of visits per year and/or per episode of care. The need for habilitation often exceeds these types of visit limits due to the complexity or difficulty of the individual in need of these services. Therefore, the CPR strongly supports a requirement in the final rule that states and issuers must establish a clearly-defined exceptions process for individuals who need habilitative services that exceed a plan’s coverage.

OPM encouraged issuers to adopt such a process in its February 2014 Call Letter to Issuers in the Multi-state Plan Program.⁵ While an exceptions process must not replace access to a full scope of habilitative services, a clearly delineated and simple appeals procedure must be available for families when a particular habilitative service is in dispute. We encourage CMS to adopt the same approach as OPM and also require plans to track requests for exceptions and their outcomes and report that information to HHS.

Prohibition of Discrimination

In its proposed rule, OPM states that an MSP issuer must hold itself to non-discrimination standards. The CPR commends this effort, as unfortunately discrimination in the health care marketplace still

⁴See *Jimmo v. Sebelius Settlement Agreement Fact Sheet*, Centers for Medicare and Medicaid Services. Available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>

⁵ Multi-State Plan Program Issuer Letter, United States Office of Personnel Management, February 2014. Available at: http://www.opm.gov/media/4518099/2014-002_multi-state_plan_program_call_letter.pdf, page 4.

exists. In the AOTA report mentioned above, approximately 14% of QHPs' Summary of Benefits and Coverages limit habilitative services coverage to enrollees based on age limits and/or health condition limits, contrary to the Affordable Care Act.⁶ New York State's benchmark benefits plan still contains a limit of one prosthetic limb per lifetime.⁷

The CPR appreciates OPM's awareness of some QHPs' discriminatory EHB benefit designs. Section 1302(b)(4) of the ACA directs the HHS Secretary to address standards in defining EHB, including discrimination in QHP design. CMS points out that some issuers have maintained limits and exclusions that were included in a State's EHB-benchmark plan. We appreciate CMS's clear guidance to issuers and States that they should not discourage enrollment of certain individuals with chronic health needs, which discriminatory benefit designs ultimately do. Additionally, we support CMS's assertion that it will notify a QHP issuer when it sees an indication of a reduction in the generosity of a health benefit when this reduction is not based on "clinically indicated, reasonable medical management practices."⁸ This is strong language that offers consumers meaningful protections from inappropriate restrictions in access EHB benefits. Therefore, we request that OPM include these same requirements in its final rule related to MSPs.

Issuers' limitations and exclusions must be based on clinical guidelines and medical evidence. The CPR continues to survey its members to ascertain which QHP issuers are not complying with the ACA's anti-discrimination and EHB provisions in their benefit designs, specifically within the category of habilitative and rehabilitative services and devices. We encourage OPM to hold QHP issuers' accountable for their violations of the ACA's anti-discrimination provisions, specifically as they relate to EHB benefit design and adverse selection of enrollees with disabilities and chronic conditions.

The CPR further recommends that OPM adopt clarification of non-discrimination standards, and provide examples of benefit designs that are potentially discriminatory under the Affordable Care Act, including but not limited to exclusions, cost-sharing, medical necessity definitions, drug formularies, visit limits, and other arbitrary restrictions in benefits as mentioned in the document "Non-Discrimination in Benefit Design" found at:

http://www.insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf.

Network Adequacy

The CPR urges CMS to adopt a network adequacy standard that require health plans to have a full range of providers in-network that are capable of providing all covered services, from preventative care to the most complex or specialized care. The use of out-of-network exceptions and appeals processes, as well as updates to provider directories cannot be a substitute for robust provider network standards.

⁶ *Analysis of Rehabilitation and Habilitation Benefits in Qualified Health Plans*, American Occupational Therapy Association, October 2014. Available at: <http://www.aota.org/-/media/Corporate/Files/Advocacy/Health-Care-Reform/Essential-Benefits/EHB-research-project.pdf>, page 11.

⁷ See *Revised Benefit Benchmark Spreadsheet*, Centers for Medicare and Medicaid Services, at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NY.pdf>.

⁸ See *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, proposed rule, Vol. 79, No. 228 of the Federal Register at p. 70717 published on Wednesday, November 26, 2014 at p. 70723.

The 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.

The CPR strongly objects to this practice. Too often enrollees across the country are diverted into nursing homes rather than inpatient rehabilitation hospitals because plans do not contract with a sufficient number of these providers. Too often, enrollees with brain injury do not receive the intensive longer term services they need because health plans do not contract with certain specialized brain injury programs. And too often, suppliers without sufficient training or expertise are called upon to provide highly complex prosthetic limb care or other specialized services and devices.

Accurate Provider Directories are Necessary but Not Sufficient: Too often individuals have enrolled in exchange plans only to find none of the providers listed in the plans' in-network provider directory are accepting new patients. The proposal to require issuers to update provider directories at least once a month should provide potential enrollees with current insights as to the true network adequacy of a plan's network. Requiring issuers to keep up-to-date provider directories will bring into focus the failure of a plan's provider network to meet ACA network adequacy standards.

The CPR sees benefit to OPM issuing regulations that would standardize how QHP issuers share network adequacy information for marketplace plans on their websites. For instance, up-to-date provider directories should include timely information on providers who are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to enrollees or prospective enrollees.

However, OPM should not stop at publication of current provider directories as its sole method of improving provider network adequacy. OPM should take an active role in overseeing a plan's network adequacy and require state-based marketplaces to do the same. QHPs must be required to report to OPM average waiting times for appointments with providers, establish a system to field complaints of provider access from plan enrollees, and hold plans accountable when their provider networks are too narrow to meet patient needs and deliver the benefits plans have been contracted with to provide.

Disability Accessibility: States and health plans 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 choose from within the state-based or federally facilitated exchanges. Additionally, 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.

Out-of-Network Care: 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, 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.

Transition of Plans and Providers: In its proposed rule, CMS highlights the importance of seamless care transitions that ensure that enrollees undergoing a course of treatment can continue their relationship with their providers during that treatment. QHP enrollees who must change plans often experience uneasy transitions between providers as a consequence of restrictive provider networks. We share CMS's view that new enrollees in QHPs may need a transition period to switch to a provider that is in-network within their new QHP, and we encourage OPM to adopt this same transition language for multi-state plans.

We support CMS's suggestion that QHP issuers using a new network of providers offer new enrollees transitional care for an ongoing course of treatment. We support extension of these benefits to health care services furnished by any provider to the new QHP enrollee, regardless of whether the provider is in the new QHP's network. This should occur as long as the enrollee received health services from that provider under an ongoing course of treatment in the 90 days prior to the effective date of coverage for the patient's new QHP. Again, OPM should adopt these provisions in its final rule.

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 Steven Postal, CPR staff, by emailing Steven.Postal@ppsv.com, or by calling 202-466-6550.

Sincerely,

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Endorsing Organizations

ACCSES

American Academy of Physical Medicine and Rehabilitation

American Association on Health and Disability

American Medical Rehabilitation Providers Association

American Music Therapy Association

American Speech-Language Hearing Association

American Therapeutic Recreation Association

Amputee Coalition

The Arc of the United States

Association of Academic Physiatrists

Brain Injury Association of America

Center for Medicare Advocacy

Christopher and Dana Reeve Foundation

Easter Seals

National Association for the Advancement of Orthotics & Prosthetics

National Association of State Head Injury Administrators

National Disability Rights Network

National Multiple Sclerosis Society

United Spinal Association