



January 17, 2016

**VIA ELECTRONIC SUBMISSION**

Andrew Slavitt  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3317-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces**

Dear Administrator Slavitt:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the draft letter entitled, *Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces* (the Draft Letter). 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. Our comments on the Draft Letter are as follows:

**Chapter 2, Section 3: Network Adequacy**

Chapter 2 of the Draft Letter describes how CMS will conduct its network adequacy review for plan year 2017 QHP certification. Pursuant to 45 CFR 156.230(a)(2), an issuer of a QHP that uses a provider network must “maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.” All issuers applying for QHP certification will need to attest that they meet this standard as part of the certification/recertification process.

**Proposed Metrics for Assessing a Qualified Health Plan’s Network Adequacy**

CPR supports the following two metrics suggested in the proposed rule *HHS Notice of Benefit and Payment Parameters for 2017*:

- 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>1</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 at least 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.

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.

## **Chapter 2, Section 10: Discriminatory Benefit Design**

This section addresses how CMS will review health plans applying to be qualified health plans (QHPs) or stand-alone dental plans (SADPs) in the Federally-facilitated Marketplaces FFMs for compliance with nondiscrimination standards. States performing plan management functions may use a similar approach.

CPR strongly encourages the HHS Secretary to move forward with further regulation of Section 1302 as a critical adjunct to the September 2015 regulations being proposed under Section 1557 (*Nondiscrimination in Health Programs and Activities*). To be clear, there have been regulations issued to implement Section 1302 (the essential health benefit (EHB) requirements generally) and 45

CFR 156.125, which is the current regulation that is intended to implement Section 1302(b)(4) of the ACA, the specific prohibitions against discrimination in the essential health benefits package. However, the CPR does not believe that 45 CFR 156.125 goes far enough in laying out specific types and examples of discriminatory benefit design, nor do we believe that HHS and the states have gone far enough in their enforcement of the non-discrimination protections of Section 1302. While health care consumers await further regulation by HHS of the non-discrimination protections of Section 1302, we believe that HHS should issue strong regulations under Section 1557 that further illustrate and elaborate on discriminatory health plan design, especially from a disability and aging perspective.

The Rehabilitation Act of 1973 and the Americans with Disabilities Act were seminal federal laws that addressed disability discrimination in a variety of settings, including to a limited extent, the provision of health insurance and health coverage. Section 504 of the Rehabilitation Act applies to the terms and conditions of insurance policies, and not simply to whether or not an individual is afforded insurance coverage. See, e.g., 28 C.F.R. Part 36, App. B, § 36.212 (Department of Justice regulations implementing Title III of the ADA, stating that “[l]anguage in the [ADA] committee reports indicates that Congress intended to reach insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified;” 29 C.F.R. Part 1630, App., § 1630.16(f) (EEOC interpretive guidance for regulations implementing Title I of the ADA, stating that a covered entity cannot deny a qualified individual with a disability equal access to insurance or subject a qualified individual with a disability to different terms or conditions of insurance based on disability alone if the disability does not pose increased risks).

Section 504 prohibits all disability-based distinctions in insurance coverage that are not justified by legitimate actuarial data or actual or reasonably anticipated experience. 29 C.F.R. Part 1630, App., § 1630.16(f). Such data or experience cannot be based on generalized information about the cost of covering individuals with a particular condition or covering particular services. CPR believes that many of the exclusions of benefits, limitations, and arbitrary caps that appear in present-day EHB plan designs are not based on actuarial data and risk violation of these federal nondiscrimination laws. We urge HHS to clearly state that Section 1557 incorporates prohibitions against this form of discrimination.

We also urge the Department to provide additional guidance concerning what constitutes disability-based discrimination in health insurance, including discriminatory benefit design, discriminatory payment structures, discriminatory network design, and discriminatory coverage decisions. The bare statement in the September 2015 proposed rule that Section 1557 prohibits discriminatory benefit design offers no information to beneficiaries about their rights under Section 1557 and no information to plan administrators, Medicaid officials, and others about their obligations under Section 1557. In order for Section 1557 to be implemented effectively, covered entities and protected individuals must have more guidance concerning the meaning of disability-based discrimination in health insurance.

This additional guidance is crucial because insurance companies discriminate against people with disabilities in a variety of ways, including through drug formularies, narrow networks, increased cost-sharing, inappropriately designed wellness programs, utilization management programs, and by imposing limitations or caps on certain services. These discriminatory practices are often driven by a desire to reduce short-term costs. However, 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 continues to survey its members and study essential health benefit (EHB) benchmark plans selected by states to determine whether such plans discriminate based on disability and age, with a focus on rehabilitative and habilitative services and devices. This benefit category is mandated by 1302 of the ACA and has been regulated more than most required benefit categories. For instance, under the February 2015 final rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, plans must:

- 1) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services) (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);
- 2) 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,
- 3) For plan years beginning on or after January 1, 2017, not impose combined limits on habilitative and rehabilitative services and devices.<sup>2</sup>

We encourage HHS to hold states and QHP issuers accountable for their violations of the ACA's anti-discrimination provisions, specifically as they relate to EHB benefit design. Specific examples of discriminatory benefit designs include the following:

- **Limitations or caps on coverage of services.** Imposing caps on coverage can easily serve as de-facto annual monetary caps on coverage, which violate ACA requirements. In the event that states impose coverage caps based on visit or service limits, federal law requires that such caps do not rely on disability-based distinctions and must be justified by legitimate actuarial data or actual or reasonably anticipated experience. Further, the CPR Coalition believes that EHB plans that do not include an *exceptions process* for patients with greater-than-average needs after a cap has been exceeded risk violation of the ACA's plan design requirements that prohibit discrimination based on disability. All EHB plans should, therefore, have an exceptions process in place if they decide to establish caps in benefits. Limitations on the number of covered visits without regard for medical necessity, best medical practices, or the extent of therapy prescribed to the individual discriminates against people with more significant disabilities who need this extensive habilitation or rehabilitation in order to gain, regain, or maintain functioning. CPR strongly encourages HHS to state that plans that discontinue benefits to patients with disabling conditions after a one-size-fits-all service cap has been reached, without individual consideration of a patient's medical needs, are at serious risk of violating Section 1557.
- **Limitations and exclusions of certain devices.** Imposing monetary caps in coverage of durable medical equipment, prosthetics, orthotics, and other devices under ACA plans is expressly prohibited. But many EHB benchmark plans impose other types of limitations and exclusions that are premised on disability-based distinctions and are not based on actuarial data. For instance, coverage exclusions of certain types of modern prosthetic limb technologies are applicable to only one disability group, individuals with limb loss. No coverage for hearing technologies or vision aids similarly impact one disability group and thereby can be considered disability-based distinctions. HHS should provide additional guidance on these forms of

discriminatory plan design so that plans and participants understand what types of benefit limitations and exclusions are not permissible.

- **Related Discriminatory Treatment of Covered Benefits.** CPR is further concerned that brain injury services might not be covered in both EHB plans and QHPs when the reason for the brain injury is related to an attempt of suicide. Coverage for EHB benefits should not be dependent on the reason or origin of the injury or condition. This clearly presents a slippery slope where health plans could deny coverage for treatment based on a wide variety of reasons. CPR is also concerned that EHB plans and QHPs continue to discriminate based on mental health conditions. HHS should clarify that this type of discrimination is impermissible under Section 1557 of the ACA and that EHB benchmark plans and QHPs that include these policies must modify them accordingly.

### **Examples of Discriminatory Plan Design Taken From EHB Benchmark Plans**

In September 2015, the CPR Coalition examined a number of proposed state EHB benchmark plans and found several common themes where we believe coverage for rehabilitative and habilitative services and devices is not in compliance with federal law. Within this category, people with disabilities experience discrimination on the basis of age, disability, and the type or severity of their disability. We have provided several examples below that HHS should include as illustrations of impermissible discrimination under Section 1557, and through future rulemaking on Section 1302. CMS should also amend the Draft Letter to reflect this guidance to issuers.

#### **Limits on Rehabilitative Services**

- Up to 20 visits per calendar year for outpatient rehabilitative services: Idaho, Wyoming
- Up to 20 visits per beneficiary period for outpatient rehabilitation services: Missouri

*Recommendation:* Failure to cover rehabilitative services under the EHB benchmark is an outright violation of the statutory provisions of the ACA. In addition, states with severe restrictions in coverage for as few as 20 visits per year or per beneficiary period—coupled with no exceptions process for those with much greater medically necessary needs—violate the non-discrimination provisions of the ACA on the basis of disability. We recommend that HHS clarify that states with severe coverage limitations such as these must revise their EHB benchmark plans, and QHPs must revise their plans' coverage limits, accordingly.

#### **Limits on Habilitative Services**

- No coverage for habilitative services: Arizona, Florida, Louisiana, Mississippi, South Carolina, Vermont, Wisconsin
- Up to 20 visits per calendar year for habilitative services: Missouri, Tennessee, Wyoming
- Limits habilitation to one condition: Alabama, Arkansas, Wisconsin



*Recommendation:* CPR believes that these provisions violate key statutory and regulatory requirements of the ACA with regard to EHB benchmark plan offerings. Failure to cover habilitation services under the EHB benchmark is an outright violation of the Section 1302 of the ACA. With respect to any state that offers coverage for as few as 20 visits per year for habilitation, we believe this severe limitation—coupled with no exceptions process for those with much greater medically necessary needs—violates the non-discrimination provisions of the ACA on the basis of disability under both Sections 1557 and 1302. We recommend that the HHS require that states revise their EHB benchmark plans, and QHPs revise their plans, accordingly.

### **Limits on Rehabilitative and Habilitative Therapy**

- 60 visits per year, combined, for rehabilitative speech therapy, occupational therapy, and physical therapy: Arizona, Maine
- 45 visits per year, combined, for rehabilitative speech therapy, occupational therapy, physical therapy, and chiropractic or osteopathic physiotherapy: Nebraska
- 30 visits per year, combined, for speech therapy, occupational therapy, and physical therapy: Alabama, Arkansas
- 25 visits per benefit period for each of habilitative speech therapy, occupational therapy and physical therapy, and rehabilitative speech therapy, occupational therapy and physical therapy: Kentucky
- 20 visits per benefit period for each of rehabilitative speech therapy, occupational therapy and physical therapy: Colorado, Indiana, Mississippi, Ohio, Tennessee

*Recommendation:* CPR believes that if states choose to impose caps in rehabilitation or habilitation therapy services, they must not rely on disability-based distinctions and 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. Although not required by federal regulations on the rehabilitative and habilitative services and devices benefit under the ACA, we believe that any therapy caps established under EHB benchmark plans should apply to different types of therapy services. For instance, if states adopt therapy caps, EHB benchmark plans should apply separate caps for physical therapy, occupational therapy, and speech therapy and each such cap must ensure access to a sufficient amount of therapy under EHB plans to meet the needs of enrollees. Of course, federal EHB regulations already require that caps in therapy benefits must be applied separately for rehabilitation and habilitation services. Finally, chiropractic services are not considered rehabilitative or habilitative services under therapy cap regulations and should be treated separately for purposes of coverage limits. We recommend that HHS clarify that states must revise their EHB benchmark plans, and QHPs revise their plans, accordingly, in order to comply with Section 1557.

### **Limits on Prosthetic Limbs**

- No coverage for prosthetic devices (i.e., artificial limbs): Utah
- Only one prosthetic device, per limb, per lifetime is covered: New York
- One item per year is covered: New Mexico
- Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, every three years: Nevada
- \$2500 limit per year for prosthetic devices. Benefits are limited to a single purchase of each type of prosthetic device every three years: Wisconsin
- \$5,000 lifetime limit for benefits related to the temporomandibular/craniomandibular joint (includes prosthetic appliances): Mississippi

*Recommendation:* Outright dollar caps in benefits are prohibited under the ACA and, therefore, caps such as the \$2,500 per year cap in Wisconsin violates the ACA and must be removed. Lifetime monetary caps are also prohibited by the ACA and, therefore, Mississippi's \$5,000 lifetime cap directly violates the ACA. Failure to cover rehabilitative and habilitation devices (e.g., prosthetic limbs, as in Utah) is a direct violation of the ACA statute and federal regulations. In addition, the "one limb, per limb, per lifetime" policy in New York violates the ACA regulations which establish that rehabilitation "devices" are covered under the rehabilitation and habilitation services and devices benefit. This limitation is also a disability-based distinction as the limitation applies only to individuals with limb loss and, therefore, violates Section 1557. We recommend that HHS clarify that states with coverage limitations such as these must revise their EHB benchmark plans, and QHPs must also revise their plans, accordingly. The Draft Letter is a major opportunity to accomplish this.

### **Limits on Hearing Aids**

- No coverage for hearing aids: Alabama, Alaska, Arkansas, California, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Michigan, Mississippi, Montana, Nebraska, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington State, Washington, DC, West Virginia, Wyoming
- Covers hearing aids only for children, while denying coverage for adults: Colorado, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Wisconsin

*Recommendation:* Hearing aids and similar technologies are "rehabilitative or habilitative devices" and, as such, must be covered under every state's EHB benefit package for 2017. Failure to cover hearing aids and similar technologies constitutes a disability-based distinction as these benefits only apply to individuals with hearing loss and, therefore, this violates both Section 1302 and Section 1557 of the ACA. Coverage of hearing aids for children only—and not for adults—also violates the ACA prohibition against discrimination in plan design based on age under both Sections 1302 and 1557. For these reasons, hearing aids are required EHB benefits and must be covered regardless of age. We recommend that HHS clarify that states with such limitations and exclusions must revise their EHB benchmark plans, and QHPs must also revise their plans, accordingly. Again, the Draft Letter is an ideal opportunity to convey this message to issuers.

We greatly appreciate your attention to our comments and recommendation with respect to the Draft Letter on discharge planning. Should you have further questions regarding this comment letter, 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,

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## **Supporting Organizations**

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 Speech-Language-Hearing Association

American Therapeutic Recreation Association

The Arc of the United States

Association of Rehabilitation Nurses

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

United Cerebral Palsy

United Spinal Association

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<sup>1</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\\_act.pdf](http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_revised_draft_proposed_revisions_mcpna_model_act.pdf).

<sup>2</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10871 (February 27, 2015).