



July 27, 2015

**DELIVERED ELECTRONICALLY**

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-2390-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Ref: CMS-2390-P Medicaid and Children's Health Insurance Program (CHIP) Programs;  
Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP  
Comprehensive Quality Strategies, and Revisions Related to Third Party Liability**

Dear Acting Administrator Slavitt:

The Steering Committee of the Coalition to Preserve Rehabilitation (CPR) appreciates the opportunity to comment on the above-referenced 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.

We appreciate CMS's effort to align Medicaid managed care rules with the rules for Medicare Advantage (MA) and private health insurance sold on the Marketplace, and to update its regulations to take into account the increasing coverage of long-term services and supports (LTSS) for people with disabilities, older adults, and children and adults with special health care needs through Medicaid managed care. Because LTSS services have not been a significant part of MA or the private insurance system, aligning Medicaid managed care rules with the rules for these systems presents some challenges. While it is clear that CMS has given serious thought to how to address these issues, there are a number of places where we think the rule should be more specific to ensure that the needs of beneficiaries with disabilities or special health care needs, and those receiving LTSS services are adequately met.

## § 438.2 Definitions

CPR supports § 438.10(c)(4)(i) that the state must develop standard definitions of terminology. We request that CMS change the reference of “habilitation services” to “habilitation services *and devices*” and “rehabilitation services” to “rehabilitation services *and devices*” to be consistent with CMS’ final rule *Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2016* and to make clear to enrollees that both services and devices are covered habilitative and rehabilitative benefits.<sup>1</sup> We also recommend that CMS add more robust definitions for habilitative and rehabilitative services and devices into § 438.2, as discussed below.

### Definition of Habilitative Services

CPR applauds CMS for codifying the National Association of Insurance Commissioners’ (NAIC) definition of habilitative services in the February 2015 final rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*.<sup>2</sup> Adopting this definition across QHPs, MCOs, PAHPs, and PHIPs would advance CMS’s goal of alignment between programs.

At the same time, we believe that the agency 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.

CMS 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.

CMS 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** including: equipment and supplies ordered by a health care professional for everyday or extended use to improve, maintain or prevent the deterioration

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<sup>1</sup> *Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2016*, Federal Register, Vol. 79, No. 228 (November 26, 2014), at 70717.

<sup>2</sup> *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, Federal Register, Vol. 80, No. 39 (February 27, 2015), available at <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

“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.” See <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>.

of an individual's functional ability. Examples of DME include, but are not limited to, manual and power wheelchairs, oxygen equipment, canes, crutches, walkers, standing system chairs, blood testing supplies for people with diabetes, as well as supplies, equipment, and repairs to support medically necessary devices.

- **Orthotics and Prosthetics** including but not limited to: leg, arm, back, and neck braces, and artificial legs, arms, and eyes, and external breast prostheses incident to mastectomy resulting from breast cancer. These services include: adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's size or 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, 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

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) definition of rehabilitative services, codified in the February 2015 final rule *Patient Protection and Affordable Care*

Act; *HHS Notice of Benefit and Payment Parameters for 2016*<sup>3</sup> and the SBC Uniform Glossary.<sup>4</sup> 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. Adopting this definition across QHPs, MCOs, PAHPs, and PHIPs would advance CMS’s goal of alignment between programs.

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:

"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.

#### **§ 438.10(c)(4)(i) – Definitions for Managed Care Terminology**

We urge CMS to include the following change for uniform adoption by MCOs:

- The terms “habilitation services” and “rehabilitation services” must be broadened to encompass devices as well as services. This is consistent with habilitation and rehabilitation terminology under the essential health benefits that QHPs must cover, and use of the same terminology meets CMS’ goal of aligning exchange and Medicaid coverage whenever possible.

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<sup>3</sup> *HHS Notice of Benefit and Payment Parameters for 2016*, available at <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

<sup>4</sup> “Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.” See <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>.

## Network Adequacy

### **§ 438.68 Network adequacy standards**

We suggest that CMS also compile plans' network adequacy standards and publish it on Healthcare.gov or Medicaid.gov on an annual basis, since many stakeholders may look for this information on a federal government website rather than looking for the website for their state Medicaid program.

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. The use of out-of-network exceptions and appeal process, as well as up-to-date provider directories cannot be a substitute for robust provider network standards.

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.

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 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.

CPR recommends that CMS require all Medicaid managed care plans to make their provider directories up-to-date and available online for publication, as the CMS February final rule mandated for QHP issuers.<sup>5</sup> Too often individuals have enrolled in exchange plans only to find none of the providers listed in plans' in-network provider directories are accepting new patients. CPR sees the benefit to CMS issuing regulations that would standardize how MCOs share network adequacy information.

However, CMS should not stop at publication of current provider directories as its sole method of improving provider network adequacy. CMS should take an active role in overseeing plan's network adequacy and require MCOs to do the same. MCOs must be required to report to CMS 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.

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 MCO they are enrolled in. Additionally, network

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<sup>5</sup> *HHS Notice of Benefit and Payment Parameters for 2016*, at 10873.

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 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.

### **§ 438.62 Continued Services to Enrollees**

In addition, the coalition commends CMS for highlighting the importance of seamless care transitions that ensure that enrollees undergoing a course of treatment can continue their relationship with their provider during that treatment.

We urge CMS to amend the criteria for when a state must require plans to offer continued access to out-of-network providers, as described below. Specifically, we recommend amending § 438.62(b) as follows:

§ 438.62(b) The state must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to a MCO, PIHP, PAHP, PCCM, or PCCM entity ~~or~~; transition from one MCO, PIHP, PAHP, PCCM, or PCCM entity to another; ***transition into a MCO, PIHP, PAHP, PCCM or PCCM entity from another insurance affordability program or private insurance; transition from an MCO, PIHP, PAHP, PCCM or PCCM entity to FFS; and when a provider leaves the enrollee's MCO, PIHP, PAHP, PCCM or PCCM entity. The transition of care policy must provide for continued access to services when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization is completing a course of treatment, has a scheduled procedure within 60 days of the transition, is receiving care for a terminal illness, is receiving prenatal or post-partum care, has a long-term relationship with a provider for treatment of a serious, complex, chronic medical condition, or the state determines that other circumstances warrant continued access.***

### **Prohibition of Discrimination**

We welcome the new reference to § 1557 of the Affordable Care Act (ACA), which prohibits discrimination from health plans.<sup>6</sup> It is clear that § 1557 applies to Medicaid MCOs, Pre-paid Inpatient Health Plans (PIHPs), and all types of Primary Care Case Manager (PCCMs). We enthusiastically support the decision to add disability as a protected category. Adding disability as a protected category provides an important broad protection for beneficiaries with disabilities that will cover discriminatory actions that many not be specifically covered by other provisions but still have a strong adverse effect. This could include instances such as when enrollees with disabilities who have high service needs or

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<sup>6</sup> See “Section 1557 of the Patient Protection and Affordable Care Act,” *US Department of Health and Human Services Office of Civil Rights*, at <http://www.hhs.gov/ocr/civilrights/understanding/section1557/>.

are difficult to deal with are treated poorly by managed care entities in an effort to get such individuals to switch managed care entities.

Issuers' limitations and exclusions must be based on clinical guidelines and medical evidence. CPR continues to survey its members to ascertain which MCOs 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 CMS to hold MCO 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.

CPR further recommends that CMS 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](http://www.insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf).

We suggest that § 438.214(c) be divided into two subsections, as follows:

(c) *Nondiscrimination*. MCO, PIHP, and PAHP provider selection policies and procedures, consistent with §438.12, must not:

~~(1) discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.~~

**(1) discriminate against particular providers on the basis of their race, color, ~~or~~ national origin, language, disability, age, sex, gender identity, or sexual orientation.**

**(2) Selection criteria shall not be established in a manner:**

**(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or**

**(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.**

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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 Steven Postal, CPR staff, by emailing [Steven.Postal@ppsv.com](mailto:Steven.Postal@ppsv.com), or by calling 202-466-6550.

Sincerely,

CPR Steering Committee

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