December 21, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Steven T. Mnuchin
Secretary of the Treasury
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Re: **Coalition to Preserve Rehabilitation (CPR) Comments on Recent Updates to Guidance for Section 1332 Waivers, State Relief and Empowerment Waivers (CMS-9936-NC)**

Dear Administrator Verma and Secretary Mnuchin:

The undersigned members of the Steering Committee of the Coalition to Preserve Rehabilitation ("CPR") write to comment on the recently-issued proposed guidance related to Section 1332 of the Patient Protection and Affordable Care Act (PPACA), entitled State Relief and Empowerment Waivers (CMS-9936-NC, issued October 22, 2018). CPR is greatly concerned that the new guidance may have significant negative implications for consumers' access to rehabilitation services and devices. We write to urge you to reconsider the guidance in light of these concerns.

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.

I. The Importance of Rehabilitative Services and Devices

Rehabilitation services are provided to help a person regain, maintain, or prevent deterioration of a skill, condition, or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition. Rehabilitation services are essential to enable people with injuries, illnesses, and disabilities to:

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

Rehabilitation services are closely related to *habilitation* services, which focus on skills, conditions, and functions that were never acquired or developed as a child. Rehabilitative and habilitative services and devices include but are not limited to rehabilitation physician services, inpatient rehabilitation hospital care, physical and occupational therapy, speech language pathology services, behavioral health services, recreational therapy, developmental pediatrics, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings. Rehabilitation also includes the provision of prosthetic limbs, orthotic braces, wheelchairs and other mobility devices, hearing technology, vision aids, speech generation devices and a multitude of other rehabilitation technologies that enhance functional outcomes.

There is a compelling case for coverage of rehabilitation services and devices for persons in need of functional improvement due to disabling conditions. These services and devices are designed to maximize the functional capacity of the individual, which has profound implications on the ability to perform activities of daily living in the most independent manner possible. Rehabilitation services and devices are highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

II. Background on Rehabilitative Services and Devices under the ACA

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

In the February 2015 Notice of Benefit and Payment Parameters Final Rule,[1] the Centers for Medicare and Medicaid Services (CMS) defined "rehabilitation services and devices" as follows:

> "Rehabilitation services and devices—Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition."

For the first time, this regulation established a uniform definition of rehabilitation services and devices that states could understand and consistently implement. This definition became a

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

standard for private insurance coverage, a floor of coverage for individual insurance plans sold on the exchanges. Importantly, the definition includes both rehabilitative *services* and rehabilitative *devices*. The adoption of a federal definition of rehabilitation services and devices minimized the variability in benefits across States and across private plans, and the uncertainty in coverage for children and adults in need of medical rehabilitation and post-acute care.

III. Essential Health Benefits

The new guidance seeks to grant states additional flexibility to tailor their state insurance markets to attempt to lower costs and, thereby, expand insurance options for consumers. While expanded coverage options and lower health care costs are two important goals, we urge you to balance these goals against the statutory requirements for EHB coverage, as well as the nondiscrimination provisions of the ACA. Adhering to these statutory requirements of the ACA will decrease the likelihood that additional flexibility will lead to the emergence of bare-bones benefit packages, particularly in the area of rehabilitation. CPR has specific concerns about the guidance's efforts to grant states additional flexibility and discretion in their insurance markets.

CPR is concerned that the additional flexibility available to states provided by the guidance may create a "race to the bottom" in the scope of coverage available to consumers in the various states. Rehabilitation services and devices are simply too important to allow States to substantially limit these benefits in their Section 1332 waivers. These benefits must be available to individuals when they truly need them. Access to rehabilitation benefits can save significant health care dollars in the long term and reduce the need for more intensive health care services later in life.

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

CPR supports the preservation of the statutory interpretation and the federal regulations defining the EHB category of "rehabilitative and habilitative services and devices." To help ensure appropriate coverage, we urge CMS to reemphasize in the guidance that regardless of added state flexibility in issuing private health plan coverage, states and plans must continue to meet the following requirements that are rooted in the ACA statute, which continues to be the law of the land with respect to benefit plan design:

- The EHB package was intended to meet the needs of individuals requiring rehabilitative and habilitative services and devices, and the ACA specifically includes language in the law to this effect.
- Limitations in benefits of any kind should be based on the best available evidence and such decisions should be made by professionals with sufficient knowledge and expertise in the rehabilitation field to render informed decisions.

- The uniform definition of rehabilitative *services* and *devices* serves as a minimum standard for covering rehabilitative benefits. These benefits should not be limited to the therapies enumerated in the federal regulation, which are merely listed as examples of covered benefits.
- Rehabilitative and habilitative services and devices should be covered without arbitrary restrictions and caps that limit the effectiveness of the benefit and undercut the purpose of the ACA's prohibition on lifetime and annual limits in benefits. If States choose to impose caps on rehabilitation therapy services, they must not rely on disability-based distinctions and any such caps must be justified by legitimate actuarial data or reasonably anticipated experience. In addition, there must be an exceptions process to meet the needs of individuals who require more therapy than the cap allows for the person with average therapy needs.
- Imposing monetary caps in coverage of durable medical equipment, prosthetics, orthotics, and other devices is expressly prohibited. Arbitrary limitations and exclusions of certain devices from an EHB benchmark plan may constitute discriminatory plan design and should not be permitted.
- Benefits cannot be defined in such a way as to exclude coverage for services based upon age, disability, or expected length of life—an explicit requirement included in the ACA.

Further, the Secretary must take into account the health care needs of diverse segments of the population, including children, persons with disabilities, and other groups.[2] This language speaks directly to the need to include in the EHB package services and devices such as rehabilitation. In addition, the Secretary must ensure that EHBs are not subject to denial to individuals against their wishes on the basis of the individual's present or predicted disability, degree of medical dependency, or quality of life.[3] CPR urges CMS to reiterate these requirements in the guidance so that states are clear that they must continue to meet these statutory protections when designing a Section 1332 waiver.

IV. Network Adequacy

The adequacy of a plan's provider network can impact the level of access to benefits for enrollees. CPR has concerns about network adequacy under the new guidance and the impact on access to rehabilitation services and devices. CPR urges CMS to ensure that, if states are given approval for a Section 1332 waiver, state review processes are sufficient to ensure that network adequacy standards safeguard access to a range of physically accessible, qualified providers across primary care, specialties, and subspecialties, without the burdens of significant travel distances and long waiting times. In addition, CMS must ensure that these standards are enforceable.

For enrollees to benefit from appropriate rehabilitation, we believe that state waivers must adhere to patient-friendly, network adequacy standards that provide ample access to the full complement of rehabilitation and habilitation service and device providers, professionals, and facilities that provide both primary and specialty care. These services should be provided based on the

[2] *See id.* § 1302(b)(4)(C).
[3] *See id.* § 1302(b)(4)(D).

individual's needs, prescribed in consultation with an appropriately credentialed clinician, and based on the assessment of an interdisciplinary rehabilitation team and resulting plan of care.

In addition to physically accessible primary care, such provider networks should include physician specialty services such as physical medicine and rehabilitation, neurology, orthopedics, rheumatology, and many other subspecialties, including physicians serving pediatric populations. They should include post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs), skilled nursing, home health, and home and community based services. They should also include physical, occupational, and speech-language therapy, audiology services, as well as recreational therapy and respiratory therapy. Durable medical equipment specialists and appropriately credentialed prosthetists and orthotists must also be included in provider networks as well as clinicians engaged in psychiatric rehabilitation, behavioral health services, cognitive therapy, and providers of psycho-social services provided in a variety or inpatient and/or outpatient settings.

People with disabilities should have access to disability-specific specialists and services, in settings that are physically accessible, and with a choice of providers—primary, specialty, and subspecialty—no matter the state in which they reside. We believe that the adequacy of a plan's provider network dictates the level of access to benefits otherwise covered under the health plan. If a plan covers a benefit but limits the number of providers or specialists under that plan, coverage will be curtailed through a lack of access to providers with sufficient expertise to treat the patient. Additionally, network adequacy standards should ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under a plan. In light of these concerns, review processes must ensure robust network adequacy standards and these standards must be strongly enforced. It is essential that Americans have access to affordable and meaningful coverage of rehabilitative services and devices through the private market.

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Access to rehabilitation services and devices is essential for the health and livelihood of people with disabilities and others in need of medical rehabilitation and post-acute care. These services also are critical for reducing downstream costs to the health care system for unnecessary disability and dependency. In order for these services and devices to be accessible, we request CMS to only approve state waivers submitted under Section 1332 of the ACA that include coverage of a robust benefit package of rehabilitative services and devices, in accordance with the statutory language and intent of the ACA. In addition, these covered services must be accessible through a range of providers across primary care, specialties, and subspecialties, without the burdens of significant travel distances and long waiting times.

CPR urges CMS to preserve access to rehabilitative services and devices in the new guidance on Section 1332 waivers in order to reduce costs to the health care system and ensure that children and adults can maximize their health and independent function through access to these services.

We greatly appreciate your attention to our concerns involving this important proposed guidance. Should you have further questions regarding this information, please contact Peter Thomas, coordinator of CPR by e-mailing Peter.Thomas@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Steering Committee of the Coalition to Preserve Rehabilitation

Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Falling Forward Foundation
National Multiple Sclerosis Society
United Spinal Association