February 21, 2013

Submitted through regulations.gov

Administrator Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8016
Baltimore, MD 21244

Re: CMS-2334-P – Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid, and CHIP, and Medicaid Premiums and Cost Sharing

Dear Administrator Tavenner:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapists, students of occupational therapy, and therapy assistants. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, disability, and other conditions. Occupational therapy practitioners and their clients in a variety of settings will be greatly impacted by this proposed rule, particularly as it relates to standards for Essential Health Benefits (EHBs). AOTA appreciates the challenges that the Centers for Medicare & Medicaid Services (CMS) faces in implementing the Affordable Care Act (ACA) and welcomes the opportunity to comment on this proposed rule.

MINIMUM STANDARDS SHOULD BE ESTABLISHED FOR DEFINING COVERAGE OF HABILITATIVE SERVICES

The proposed rule includes no language establishing requirements related to coverage of habilitative services. Instead, in the preamble to the proposed rule, CMS requests comments regarding the following questions:

1. Should "the state defined habilitative benefit definition for the exchanges…apply to Medicaid?"
2. Should states "be allowed to separately define habilitative services for Medicaid?"
3. Should "the habilitative benefit…be offered in parity with the rehabilitative benefit?"

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States should not be permitted to apply definitions of the habilitative benefit for the private insurance market to Medicaid. Instead, states should be required to define habilitative services through a public process that establishes minimum standards for coverage, while taking into account the unique circumstances of the Medicaid-eligible population, including the impact of a restrictive definition on access to critical services in early intervention and special education. Medicaid beneficiaries, by definition, have fewer resources than persons who will be purchasing private health insurance, and therefore, the difficulty of obtaining services not covered by Medicaid should be taken into account. In fact, services not covered by Medicaid will almost certainly be inaccessible to Medicaid beneficiaries.

In addition, a majority of states have not yet established definitions of habilitative services for their private insurance markets, and may not do so until after this Medicaid rule has been finalized. CMS should not approve states' use of definitions of coverage for a statutorily required service category that do not yet exist, since the adequacy of those definitions cannot be evaluated. This is even more apparent given the evidence of the inadequacy of some of the definitions that have been developed pursuant to the EHB implementation process up to this point. For example, Ohio's definition explicitly references only pediatric services for children with an autism diagnosis.[1] It allows health plans to determine any additional habilitative benefits to be offered. While AOTA believes Ohio's definition is inadequate for the private insurance market as well, it is even less appropriate for Medicaid, and we believe is inconsistent with the nondiscrimination requirements of the ACA and this proposed rule.[2]

Furthermore, some states established definitions of habilitative services for their private insurance markets with no public input.[3] There is evidence that many decision makers are not familiar with the nature or purpose of habilitative services, and therefore should not define the benefit category without stakeholders being permitted to offer input. Other states have done nothing more to define the benefit than indicate it must be covered at parity with rehabilitation,[4] which fails to take into account the distinct nature of habilitative services, and invites the possibility that states may not distinguish between rehabilitation and habilitation when establishing the scope of coverage.[5]

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[1] Ohio's Governor defined the benefit category in a comment letter addressing the EHB proposed rule: http://healthtransformation.ohio.gov/LinkClick.aspx?fileticket=05FcqO9BWig%3d&tabid=161.

[2] "Essential health benefits cannot be based on a benefit design that discriminates on the basis of an **individual's age**…present or predicted disability…or other **health conditions**." [Emphasis added]: 78 Fed. Reg. 4701 (proposed January 22, 2013) (to be codified at 42 C.F.R. pt. 440.347(e)).

[3] For example, Michigan's Office of Financial and Insurance Regulation issued an order defining the benefit with no public notice: http://www.michigan.gov/documents/lara/1.7.13_Order_No_13-003-M_EHB_Habilitative_Services_407955_7.pdf. Ohio's decision was similarly made without public input.

[4] For example, Nevada and Kansas did this: http://doi.nv.gov/sinfo/doc/12.14.12_kipper_letter_re_ehb.pdf and http://www.ksinsurance.org/consumers/healthreform/ehb_hearing_2012/KID_COMMENTS_ON_HHS_EHB_PROPOSED_RULE%2012-26-2012.pdf.

[5] For example, the coverage of habilitative services listed in Appendix A of the EHB rule suggests many states may simply add coverage of habilitative services to the rehabilitation benefit, without an increase in the scope or duration of the benefit. That fails to take into account the differences between rehabilitative and habilitative services.

For the aforementioned reasons, AOTA requests that CMS take this opportunity to ensure states meet the following minimum requirements when defining habilitative services:

- Coverage of habilitative services should be distinct from coverage of rehabilitative services.
- Coverage should not be limited by age[6] or medical condition.
- Coverage requirements should explicitly mention the three core therapy services recognized by the National Association of Insurance Commissioners (NAIC), i.e., occupational therapy, physical therapy, and speech-language pathology.[7]
- The definition should be consistent with the NAIC definition and the existing Medicaid definition[8] and include coverage for acquisition, retention, and improvement of function.
- There should be no exclusion for services that may be educationally-relevant, as is the current policy in Medicaid.
- Availability of habilitative benefits should be based on determinations of need instead of arbitrary limits, but if quantitative limits are imposed, they should be separate from and **at least** at parity with those for rehabilitative services.

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AOTA also supports the comments submitted by the Habilitation Benefits Coalition and the Consortium for Citizens with Disabilities. AOTA respectfully requests that careful consideration be given to these comments. Should you have any questions or require additional information, please contact us at (301) 652-6611 ext. 2016 or dbrown@aota.org.

Respectfully submitted,

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[6] In particular, because the expansion population will be comprised largely of adults.

[7] "Habilitation Services - 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." http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf.

[8] "[T]he term 'habilitation services' means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and includes prevocational, educational, and supported employment services…." Social Security Act § 1915(c)(5)(A).