February 21, 2013

VIA ELECTRONIC SUBMISSION

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

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 undersigned members of the Habilitation Benefits (HAB) Coalition appreciate the opportunity to comment on the proposed rule *Medicaid, Children's Health Insurance Programs, and Exchanges* (CMS-2334-P). The HAB Coalition is particularly interested in commenting on the inclusion and definition of habilitative services as part of an essential health benefits (EHB) package in the alternative benchmark plans ("ABPs") for the new adult eligibility group under the expansion of Medicaid. The HAB Coalition is a group of national nonprofit consumer and provider organizations focused on securing appropriate access to, and coverage of, habilitation benefits within the category known as "rehabilitative and habilitative services and devices" in the EHB package under the Patient Protection and Affordable Care Act (ACA), Section 1302.

Habilitation Standards for Alternative Benchmark Plans

In its final rule for essential health benefits for exchanges, HHS allows issuers to determine coverage for habilitative benefits absent a state definition. The HAB Coalition strongly objects to issuer-defined EHBs and we appreciate that HHS omitted this option in the Medicaid benefits regulation.

The HAB Coalition's strong preference is for a federal standard for the habilitative benefit within Alternative Benchmark Plans (ABPs). Toward that end, we recommend HHS incorporate a minimum model habilitative benefit into § 440.347(d) for adoption by states.

For a definition, HHS should consider Medicaid's long history with habilitation[1], as well as the National Association of Insurance Commissioners' (NAIC) definition of habilitative 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" (NAIC Glossary of Terms for the ACA).

Since HHS has incorporated the NAIC definition into glossary and explanation documents for the exchanges, the NAIC definition should provide some consistency between exchange coverage and ABP coverage. In its model definition, HHS should include a set of habilitative services specifying the minimum types of services to be provided (e.g., occupational therapy, physical therapy, speech-pathology and other services for people with disabilities in a variety of inpatient and outpatient settings), and should specify that these services are a floor. In addition, ABPs must cover habilitative devices, such as durable medical equipment (e.g., wheelchairs), orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech, and other assistive technologies and supplies.

Minimum Parameters for Habilitative Coverage

HHS should require that when states adopt and develop a habilitative benefit for the ABP, that they follow the listed parameters:

- Cover habilitation services and devices which help a person keep, learn or improve skills and functioning, as defined by the HHS Summary of Benefits and Coverage regulation;
- Cover habilitation separate and distinct from rehabilitation. For example, the plan cannot substitute rehabilitation for habilitation or apply only a single visit limit to both benefits.[2] Each benefit must be based upon medical necessity, and not be subject to an arbitrary cap on the number of visits;[3]
- Cover habilitative services without age restrictions – a pediatric-only habilitative benefit is inadequate, especially as the new eligibility category is for adults only. Some children

[1] The Medicaid program defines habilitation as "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." Social Security Act, Section 1915 3(c)(5)(A).

[2] 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 and would discourage enrollment by anyone in need of these medical services.

[3] Coverage of habilitative services and devices without arbitrary limits is especially important for children who may suffer from a condition at birth (such as cerebral palsy, autism or spina bifida) or from an illness or injury, that prevents normal skills development and functioning. Receiving sufficient habilitative services that helps the child *acquire*, improve, or retain a skill or level of functioning that they did not previously possess can mean the difference between talking and not talking, walking and not walking, or needing special education and being able to join a regular classroom. Some children will need habilitative services only for a short time, while others will need them on an ongoing basis to ensure that hard-earned skills are not lost or, in the case of children with cerebral palsy, for example, so their muscles function as well as possible.

will continue to need habilitative services as they move into adulthood to retain the skills they acquired as a child.

- States must evaluate their ABP habilitative benefit separate from coverage in the Exchange; they cannot simply adopt the definition or coverage limits used in the Exchange for Medicaid ABPs.
- Prohibit 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) or other utilization management tools on habilitative services and devices that are more restrictive than the predominant requirements or limitations that apply to all other benefit categories;
- Cover habilitative devices without arbitrary restrictions and caps that limit the effectiveness of the benefit;[4] and
- Prohibit the exclusion of specific conditions or diagnosis from accessing the benefit.[5]

Evaluation of the Coverage of Habilitative Services and Devices

Given the considerable amount of questions HHS has regarding habilitation, we urge HHS to stipulate in the final regulation an ongoing federal and state process for data collection and evaluation to identify and address any gaps in ABP and exchange coverage of habilitative services and devices.

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 Theresa Morgan, Habilitation Benefits Coalition staff, by emailing Theresa.Morgan@ppsv.com or by calling 202-466-6550.

Sincerely,

American Academy of Physical Medicine and Rehabilitation
American Association on Health & Disability
American Occupational Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Children's Hospital Association
Christopher & Dana Reeve Foundation
Family Voices
National Association of Social Workers
Paralyzed Veterans of America
The Arc of the United States

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[4] As they grow, children will need frequent replacements of devices such as wheelchairs, glasses, orthotics and prosthetics, and as their skills develop, they may need new augmentative communications devices. For example, a child who gets a wheelchair or prosthetic limb at age 2 will need new devices as they grow.

[5] For example, Tennessee appears to be limiting the rehabilitative and habilitative benefit to conditions resulting from an acute disease, injury, autism in children under age 12, or cleft palate. This suggests that individuals with other developmental disabilities such as intellectual disability or cerebral palsy would not be able to access rehabilitation or habilitation services.