



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

October 21, 2011

Donald M. Berwick, MD, MPP  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
*Attention: CMS-9982-P, CMS-9982-NC*

**RE: Proposed Rule and Notice for Comment on Summary of Benefits and Coverage and Uniform Glossary [CMS-9982-P], [CMS-9982-NC]**

Dear Administrator Berwick:

The Consortium for Citizens with Disabilities Health Task Force appreciates the opportunity to comment on the proposed rule and notice for comment regarding the disclosure of the summary of benefits and coverage (SBC) and the uniform glossary to be made available to consumers within the new health insurance exchanges, as mandated by the Patient Protection and Affordable Care Act, amended by the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act or “ACA”).

It is critical to health insurance consumers with disabilities and chronic conditions, and those that acquire disabilities and conditions after purchasing insurance, that HHS appropriately define ACA’s essential health benefits category “rehabilitative and habilitative services and devices.” Consumers need to be fully informed of the coverage levels and limitations and/or exclusions for these critical services and devices prior to determining which health plan to purchase.

**I. Support for Included Definitions**

CCD supports the adoption in the health insurance exchanges of consumer materials developed by the National Association of Insurance Commissioners (NAIC)’s in coordination with the Consumer Information (B) Subgroup, that address certain definitions of medical and insurance terms. For instance, it is important that consumers understand the definitions of medical terms such as “rehabilitation services,” “habilitation

services” and “durable medical equipment” found in the proposed regulation. The proposed rule defines these terms as follows:

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that 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.

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.

Durable Medical Equipment

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

We strongly support the emphasis on *functioning* for daily living in the rehabilitation and habilitation definitions. Critically, these services help people with disabilities maintain their independence in the community and avoid secondary conditions by helping them improve, restore, maintain or prevent deterioration of their ability to function in daily life. It is also critical that consumers understand that rehabilitation and habilitation services encompass inpatient and outpatient care in a variety of settings, such as an inpatient rehabilitation hospitals, acute hospitals, skilled nursing facilities, long term care hospitals, home health agencies, private practices and other settings.

In addition, CCD supports the current definition of durable medical equipment or “DME,” and agrees that this term should not be defined as medical equipment that is useful “in the patient’s home” only, as the Medicare program describes it. This exclusionary language in the definition of Medicare DME has prevented individuals from accessing medical equipment needed to be mobile and as independent in the community setting. Durable medical equipment represents a range of assistive technology and devices that are critical to the independence and well being of people with disabilities.

**II. Recommendations for Additional Definitions**

CCD is very concerned that the terms “orthotics” and “prosthetics” were not defined by the NAIC and that HHS has not included definitions for O&P in the materials. Appropriate O&P care can mean the difference between a life of disability and

dependency and a life of full function, self-sufficiency, and independence. Orthotics and prosthetics entail a high level of clinical service by educated and trained practitioners who design, fabricate and fit custom orthoses and prostheses.

Categorizing O&P care under the definition as DME applies a spectrum of rules intended for DME to a field that is very different in critical respects and causes major problems in appropriately regulating the provision of orthotic and prosthetic care. This is the reason why Medicare defines DME separately from O&P and uses the term “DMEPOS,” (durable medical equipment, prosthetics, orthotics, and supplies) to describe these items and related services.

The Affordable Care Act requires the HHS Secretary to define the term “durable medical equipment,” among other medical terms, and grants the Secretary discretion to define additional terms as she deems necessary. (Patient Protection and Affordable Care Act, Pub. L. No: 111-148, Sec. 1001) CCD recommends that CMS exercise its discretion and establish a separate definition of “orthotics and prosthetics” to inform private health insurance consumers of the specific coverage levels of each of these important benefits.

Indeed, the ACA’s legislative history lays the foundation for CMS to use its discretion to include a separate definition in the list of medical terms for “Orthotics and Prosthetics.” House Education and Labor Committee Chairman George Miller at the time of the ACA’s passage in the House explicitly stated that Congress intended to include prosthetics and orthotics in the new health care law’s essential benefits package under the term “rehabilitation and habilitation services and devices,” but also intended to define prosthetics and orthotics separately from DME in the definitions section of the Affordable Care Act. **“It is my expectation ‘prosthetics, orthotics, and related supplies’ will be defined separately from ‘durable medical equipment,’”** Miller stated. (Congressional Record, H-1882, March 21, 2010).

CCD recommends the following definition for prosthetics and orthotics:

“Prosthetics” include artificial legs, arms, and eyes and “orthotics” include leg, arm, back and neck braces that are ordered by a health care provider, including replacements due to wear, damage, or a change in the person’s condition.

### **III. Recommendations for Edits of Included Definitions**

CCD is concerned with the proposed definition for use in consumer documents of the term “medical necessity.” The proposed definition of medical necessity, perhaps inadvertently, may exclude a broad range of individuals who have critical health care needs, such as persons with conditions such as a mental or substance use disorder, developmental disability or congenital problem. As currently drafted, the definition of medical necessity appears to link coverage to “illnesses” and “injuries” but not to physical and mental health conditions that may arise from causes unrelated to either an illness or injury, particularly in the case of people whose disabilities are present from

birth. As such, the proposed definition may undermine the non-discrimination provisions of the Affordable Care Act by permitting insurers to exclude as not “medically necessary” otherwise covered treatments and services, the need for which arise from a “condition” rather than an illness or injury. The proposed definition reads:

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an *illness, injury, disease or its symptoms* and that meet accepted standards of medicine. (Emphasis added.)

Therefore, we strongly recommend that the final rule amend the proposed definition of “medical necessity” to ensure that coverage is not jeopardized for people with disabilities, including those with mental or substance use disorders. Specifically, we propose that the definition of medical necessity be amended to add the word “condition” as follows “... illness, injury, disease, **condition** or its symptoms...”

In addition, while appreciate the focus on qualified professionals in the definition of “Provider,” we note the absence of reference to federal accreditation requirements. The proposed definition reads as follows:

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility *licensed, certified or accredited as required by state law.*” (Emphasis added.)

In all settings, high quality care should be provided by fully accredited programs and professionals. Accreditation, licensure and certification are important mechanisms to measure quality and accountability of health care providers and the services and devices they provide, which is particularly important for individuals with complicated conditions. While licensure is traditionally regulated by the state, federal health care programs including the Veterans Administration and Medicare have federal accreditation standards. These standards should also be recognized in the definition, and we recommend that the definition be edited to read “... as required by federal and state law.”

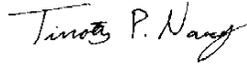
Thank you for your consideration of our views. Please contact any of the Health Task Force co-chairs listed below with questions.

Sincerely,

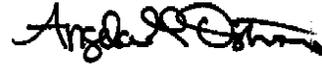
CCD Health Task Force Co-Chairs:



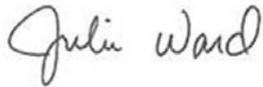
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