

January 31, 2012

***Submitted to EssentialHealthBenefits@cms.hhs.gov***

Secretary Kathleen Sebelius  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Director Steve Larsen  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7501 Wisconsin Avenue, West Tower  
Bethesda, MD 20814

**Re: Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (December 16, 2011)**

Dear Secretary Sebelius and Director Larsen:

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, and disability. Occupational therapy practitioners and their patients in all settings will be greatly impacted by Department of Health and Human Services (HHS) plans to define essential health benefits under section 1302 of the Patient Protection and Affordable Care Act (ACA), and AOTA appreciates the opportunity to comment on the Essential Health Benefits Bulletin released by the Center for Consumer Information and Insurance Oversight (CCIIO) (December 16, 2011).

**I. THE INTENDED REGULATORY APPROACH IS INSUFFICIENT AND NOTICE-AND-COMMENT RULEMAKING UNDER THE APA IS APPROPRIATE**

Essential health benefits (EHB) are intended by the ACA to serve as the floor for what benefits many health plans must cover going forward. HHS is given sole statutory authority to define EHB<sup>1</sup> and the Department's intended regulatory approach to defining these benefits and setting this floor was outlined in the Essential Health Benefits Bulletin released last month.<sup>2</sup> Instead of creating one national minimum benefit package, however, HHS outlined a plan allowing each state to adopt its own definition of EHB, within certain parameters. States may

<sup>1</sup> Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, §1302(b)(1), 124 Stat. 164, 45-6 (2010).

<sup>2</sup> Center for Consumer Information and Insurance Oversight (CCIIO), *Essential Health Benefits Bulletin* (2011).

select one of four benchmark plan types to serve as the standard for 2014 and 2015, and HHS will not assess the coverage adequacy of selected benchmark plans until 2016.<sup>3</sup>

The four plan types states may select are limited to the following: (1) any of the three largest Federal Employees Health Benefits Program (FEHBP) plans by enrollment, (2) any of the three largest state employee health benefit plans by enrollment, (3) the largest plan by enrollment in any of the three largest small group insurance products offered in the state, or (4) the largest commercial non-Medicaid Health Maintenance Organization (HMO) plan in the state.<sup>4</sup> This state-based, benchmark approach could result in 50 different EHB floors, far from the national standard that legislators, consumers, and providers envisioned or the premium target approach recommended by the Institute of Medicine.<sup>5</sup>

AOTA believes that this approach is unwieldy, untenable and does not go far enough to create a true minimum benefit package that would protect consumers across the country, particularly vulnerable populations such as children and persons with disabilities. Over reliance on the states is a departure from HHS' statutory directive, and HHS must follow notice-and-comment rulemaking procedures under the Administrative Procedure Act (APA)<sup>6</sup> to finalize federal regulations that define EHB for all. The onus is on HHS to define this important set of benefits, not the states, and the statute requires that the definition be promulgated via notice and comment rulemaking:

*(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—*

- (1) provides for the essential health benefits **defined by the Secretary** under subsection (b);*
- (2) limits cost-sharing for such coverage in accordance with subsection (c); and*
- (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in sub- section (d).*

*(b) ESSENTIAL HEALTH BENEFITS.—*

*(1) IN GENERAL.—Subject to paragraph (2), the **Secretary shall define the essential health benefits**, except that such benefits shall include at least the following general categories and the items and services covered within the categories:*

...

*(2) LIMITATION.—*

...

*(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the **Secretary shall provide notice and an opportunity for public comment.***<sup>7</sup>

...

HHS may not simply defer to the states to set the EHB floor and then employ subregulatory guidance to fill in any gaps. AOTA asks that HHS continue to solicit stakeholder comments on

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<sup>3</sup> CCIIO Bulletin, Sec. C: 8.

<sup>4</sup> CCIIO Bulletin, Sec. B: 9.

<sup>5</sup> Institute of Medicine (IOM), *Essential Health Benefits: Balancing Coverage and Cost* (2011).

<sup>6</sup> 5 USC §§551 *et seq.*

<sup>7</sup> ACA §§1302(a) and (b)(3) [emphasis added].

appropriate definitions and parameters for the 10 benefit categories identified in the ACA, and ultimately propose a set of clear, comprehensive, national definitions via a Notice of Proposed Rulemaking published in the *Federal Register*.

## **II. MAINTENANCE OF FUNCTION IS PROPERLY INCLUDED IN THE DEFINITION OF HABILITATIVE SERVICES**

In the Bulletin, HHS recognizes that federal insurance programs have definitions for habilitation coverage that include “maintenance of function,” but notes that many commercial payers exclude such language from their coverage policies. Citing this gap, HHS seeks comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services. AOTA submits that the advantages are many: protection of children and persons with disabilities for whom habilitative care is necessary and fundamental; promotion of evidence-based, high quality, cost-effective care; advancement of ACA goals; and consistency across programs and reliability for consumers as they change insurers and navigate plans.

### **A. Maintenance of Function Coverage is Key to Evidence-Based, High Quality, Cost Effective Care in Furtherance of ACA Goals**

Evidence shows that interventions enabling persons to maintain their function are high quality and cost-effective. Maintenance of function therapy can halt deterioration, help prevent harmful and costly secondary conditions, allow for independent living and greater participation in the community, all while limiting expensive inpatient admissions and readmissions, other costly care, and negative social effects. Maintenance of therapy is particularly important for children and persons born with disabilities, populations who never possessed certain functional skills and must receive habilitative services to attain such skills and maintenance of function therapy to keep them. Each aspect of maintenance therapy also advances the ACA’s aim to focus on preventive care and balance cost and coverage, and AOTA thus believes “maintenance of function” must be included in the EHB definition of “habilitative services.”

As an illustration, children with neurological disorders (*e.g.*, autism, cerebral palsy) need maintenance therapy during their ongoing development. The absence of skilled maintenance therapy for these children will result in serious deterioration of functional use of their body, leading to greater disability as well as an increased dependence on others for care. Similarly, adults with neurological disorders (*e.g.*, stroke, multiple sclerosis) also require maintenance therapy to prevent deterioration and secondary conditions. Because maintenance therapy helps such patients avoid exacerbations of their conditions as well as avoid the development of secondary conditions, it is properly considered a type of preventive care. Providing high quality, cost-effective preventive services is consistent with the aims of health care reform legislation, and limiting EHB coverage to solely reactive care would be neither cost-effective nor forward-looking.

Available evidence supports the value of maintenance therapy and its nature as both medically necessary and preventive care, bolstering AOTA’s belief that it is advantageous to add “maintenance of function” to the definition of “habilitative services.” A systematic review of the

literature shows that occupational therapy practitioners are instrumental to retaining function and community participation when a patient experiences a decline in health, and that therapies to maintain function can lead to reduced pain, increased physical activity and disability, and improved long-term participation in exercise.<sup>8</sup> In addition, group occupational therapy, where appropriate, has also been proven to slow a patient's rate of functional decline and give patients the skills they need to use assistive technology to maintain independence rather than rely on assistance from others.<sup>9</sup>

Another study noted that therapeutic interventions are proven to improve outcomes in the acute and chronic phase after stroke, but a significant amount of this improvement has been shown to be lost after one year. With maintenance interventions from a qualified therapist (provision of constraint-induced movement therapy using a constraining splint and completion of individually-tailored tasks for two hours a day), however, patients were able to recoup these losses.<sup>10</sup>

Functional and quality of life issues have become increasingly recognized as important, both in federal and state legislatures and in emerging research. As part of this development, there is rising interest in evidence-based, skilled interventions to manage "transitions." For children and young adults with autism and other disabilities, who struggle to retain the skills they are learning as they transition through various life stages, avoiding deterioration in their functional abilities can mean the difference between graduating from high school vs. dropping out, or living independently vs. living in an institution.<sup>11</sup> Yet other systemic studies broadly demonstrate the degree to which community-based health promotion and prevention efforts from occupational therapists can improve the health and well-being of older adults – an important aim of the ACA.<sup>12</sup> As persons with disabilities transition into middle and later adulthood, there is an enormous physical and psychological burden associated with having to manage various health conditions in addition to managing the health effects of aging. In this environment, tasks that might have been once easily accomplishable can become major obstacles and it can be a struggle for one to continue doing what they have always done. Evidence suggests that a long-term

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<sup>8</sup> Marian Arbesman & Letha J. Mosley, *Occupation- and activity-based health management and maintenance interventions for productive aging*, AMER. J. OF OCCUPATIONAL THERAPY 66(3) (2001); for more on prevention and physical activity see MP Galea, *Spinal cord injury and physical activity: preservation of the body*, SPINAL CORD (2011) 1-8; PJ Manns et al., *Addressing the nonexercise part of the activity continuum: a more realistic and achievable approach to activity programming for adults with mobility disability?* PHYS. THER. (2012); LM Spencer et al., *Maintaining benefits following pulmonary rehabilitation: a randomized controlled trial*, EUR. RESPIR. J. 35 (2010) 571-77.

<sup>9</sup> Dorothy Wilson, et al., *Effects of assistive technology on functional decline in people aging with a disability*, ASSISTIVE TECH. 21 (2009) 208-217.

<sup>10</sup> Michel Rijntjes et al., *Repeat therapy for chronic motor stroke: a pilot study for feasibility and efficacy*, NEUROREHABIL. & NEURAL REPAIR, 23(3) (2009) 275-280.

<sup>11</sup> Meira L. Orentlicher & Laurette J. Olson, *Transitions From School to Adult Life for Students With an Autism Spectrum Disorder*, in AUTISM: A COMPREHENSIVE OCCUPATIONAL THERAPY APPROACH (Heather Miller Kuhaneck, ed. 2010).

<sup>12</sup> Wendy B. Stav, et al. (in press), *Evidence related to occupational engagement and health outcomes among community-dwelling older adults*, AMER. J. OF OCCUPATIONAL THERAPY.

maintenance plan is necessary for participation and to avoid the loss of essential functional gains.<sup>13</sup>

The research in existence (only some of which is cited above) is strong and clear as to the benefits of maintenance for various populations, though AOTA wishes to note that our evidence continues to grow and develop. We ask that evidence and comparative effectiveness research not be used to inappropriately limit or restrict EHB coverage of and access to therapies, treatments, assistive devices, and long term services and supports for persons with disabilities and chronic illnesses. Much of the research on care necessary for these populations to function and participate in their communities is in its infancy, especially research regarding children with autism and other disabilities, and limited data alone does not mean an intervention is not proof that a therapy is ineffective or unnecessary.

Finally, we wish to stress that narrowly constraining the definition of habilitation to exclude maintenance of function would thus keep vast numbers of privately-insured people from receiving medically necessary care that can dramatically improve their function and their ability to participate in their communities. Such a constraint would disproportionately impact the very patient populations mentioned above and targeted by health care reform legislation: children and persons with neurological conditions and chronic conditions like Alzheimer's disease, arthritis, multiple sclerosis, Parkinson's disease, and spinal cord injuries, stroke, and traumatic brain injury. The advantages of including maintenance language in the definition of habilitation far outweigh any real or perceived disadvantages.

## **B. Only Qualified Providers May Provide Habilitative Services**

AOTA must also emphasize that any definition of habilitative services must include clear language that covered services are to be provided by qualified providers who are appropriately educated, trained, and licensed or otherwise credentialed under state law. Our view is that only providers who are highly qualified and properly regulated should be considered by HHS for inclusion in an EHB floor. Any immediate cost savings achieved by allowing unqualified (or under-qualified) providers to furnish habilitative and rehabilitative services could result in long-term increased costs to care for preventable, avoidable conditions. Providers qualified to provide skilled habilitative and rehabilitative services across care settings include practitioners of occupational therapy, physical therapy, and speech-language pathology.

## **C. Existing Esteemed Definitions of Habilitation Include Maintenance of Function**

Respected definitions of habilitation that include maintenance language are varied and found throughout the public, private, and non-profit domains. A sampling of these inclusive definitions is offered here to demonstrate that the field of habilitation/rehabilitation accepts maintenance of function as an integral aspect of care and show how the inclusion of such language in the EHB definition would promote consistency and the exclusion would contravene principles undergirding the Medicare program.

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<sup>13</sup> James H. Rimmer, *Exercise and physical activity in persons aging with a physical disability*, PHYS. MED. REHABIL. CLIN. N. AM. 16 (2005) 41-56.

## 1. Federal Definitions

The Social Security Act, federal regulations, and Medicare Manuals all provide for coverage for maintenance of function within the Medicare program. The Social Security Act does not exclude medically necessary maintenance from Medicare coverage for illness or injury (only once requiring improvement as a precondition to coverage for “malformed body member[s]”).<sup>14</sup> Federal Medicare regulations have interpreted this statutory language to include maintenance, stating:

*The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or **preserve current capabilities**...*<sup>15</sup>

The regulations go on to explicitly support coverage if the condition will improve “**or** the skills of a therapist [are] necessary to perform a **safe and effective maintenance program**.”<sup>16</sup> Interpretative guidance throughout the Medicare manuals often echoes Medicare regulations and bases coverage on a patient’s unique needs, allows for maintenance-related services, and does not employ a strict standard of functional improvement.<sup>17</sup>

Additionally, the Medicaid definition for “habilitation services” explicitly includes the concept of maintenance of function:

*... 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...*<sup>18</sup>

Furthermore, for purposes of developing a summary of benefits and coverage template and a uniform glossary for use by individual and group health plans, as mandated by the ACA and Public Health Service Act (PHS), the Departments of Health and Human Services, Labor, and the Treasury adopted in full the definition of “habilitation services” recommended by the National Association of Insurance Commissioners (NAIC). This definition notably includes the concept of maintenance of function:

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<sup>14</sup> 42 USC §1395y(a)(1)(A) (Medicare allows coverage when services are medically “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”)

<sup>15</sup> 42 CFR §409.32(c) [emphasis added].

<sup>16</sup> 42 CFR §409.44(c)(2)(iii) [emphasis added].

<sup>17</sup> See, e.g., Medicare Benefit Policy Manual (MBPM), Pub. 100-02, Ch. 15, §220.2(B) (stating that in order for therapy services to be covered as reasonable and necessary “there must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, **or** the services must be necessary for the establishment of a safe and effective **maintenance program**” [emphasis added]); MBPM, Ch. 7, § 40.1.1 (requiring, *inter alia*, that the determination of coverage for skilled care be “based solely upon the patient’s unique condition and individual needs... In addition, skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable”).

<sup>18</sup> Social Security Act §1915(c)(5)(A); 42 USC §1396n(c)(5)(A) [emphasis added].

*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.<sup>19</sup>*

Both the functional and explicit definitions of habilitation for federal payers are inclusive of maintenance language and this should be extended to EHB and the exchanges as well.

## 2. Specialty Definitions

AOTA and other disability advocates have long recognized the value of maintenance of function and include this aspect of care in coverage definitions we draft, support, and promote. The Consortium for Citizens for Disabilities (CCD), of which AOTA is a member and leader in its Health Task Force, has supported the following language regarding maintenance of function coverage for many years:

*The CCD believes that a federal definition of medical necessity should require plans to cover services that are: calculated to prevent, diagnose, correct, or ameliorate a physical or mental condition that threatens life, causes pain or suffering, or results in illness, disability, or infirmity; calculated to **maintain or preclude deterioration of health or functional ability**; individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness, disability, or injury under treatment; not in excess of the individual's needs; necessary and consistent with generally accepted professional medical standards as determined by the Secretary of Health and Human Services or the state Department of Health; and reflective of the level of service that can be safely provided and for which no equally effective treatment is available.*

Internationally, the World Health Organization (WHO) also includes the concept of maintenance of function in its definition of rehabilitation (which is itself inclusive of both rehabilitation and habilitation):

*This Report defines rehabilitation as “a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and **maintain optimal functioning** in interaction with their environments.”*

...

*Rehabilitation measures target body functions and structures, activities and participation, environmental factors, and personal factors. They contribute to a person achieving and **maintaining optimal functioning** in interaction with their environment, using the following broad outcomes:*

- *prevention of the loss of function*
- *slowing the rate of loss of function*

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<sup>19</sup> Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions, and Related Materials Under the Public Health Service Act [CMS-9982-NC], Appendix E, 76 *Fed. Reg.* 52475, 52529 (August 22, 2011); NAIC Glossary of Health Insurance and Medical Terms: 2 [emphasis added]. The adopted NAIC definition of rehabilitation services also includes maintenance of function language.

- *improvement or restoration of function*
- *compensation for lost function*
- *maintenance of current function.*<sup>20</sup>

As evidenced by the definitions above, including maintenance of function in the EHB definition of “habilitation services” would promote consistency across programs and reliability for consumers.

#### **D. Need for Reciprocal Benchmarks**

Lastly, AOTA recommends that, regardless of how habilitation is ultimately defined, HHS require that all benchmark plans cover habilitative services at parity with rehabilitative services. The only meaningful difference between habilitation and rehabilitation is the reason for the need for the services, and plans should not be permitted to deny these benefits.

### **III. BENEFIT DESIGN FLEXIBILITY MUST NOT IMPEDE ACCESS**

HHS states in the Bulletin that it intends to require that health plans offer benefits that are “substantially equal” to the benefits of the benchmark plan selected by the state. This purpose is to allow plans flexibility in adjusting benefits, including both the specific services covered and any quantitative limits. AOTA has concerns with such an approach, and asks that HHS ensure that a “substantially equal” standard does not lead to a reduction in patient access to services or an increase in-out-of-pocket payments.

Health insurance plan benefits should not be arbitrarily or absolutely limited for all patients. We have seen in Medicare, for instance, that arbitrary caps on access to rehabilitation services have significant negative consequences. Instead of a “substantially equal” standard, plans should approach the needs of certain outlier consumers with an individualized approach, and medical review of medically necessary services should be done by peers. For instance, review of occupational therapy should be completed by occupational therapists.

In this era before all ACA reforms are fully implemented, health plans are not invested in furnishing preventive care or achieving quality outcomes through the provision of appropriate services. This is due to the fact that the long term health problems and costs of their consumers are likely to be borne by another insurer because consumers are forced by economics (plan cost) and circumstance (employment changes) to frequently change plans. AOTA consequently believes that case management of individuals whose needs are significant or are otherwise outside the average norms be handled not with the blunt instrument of quantitative limits, but with the appropriate use of case and utilization management based on what is best for the long-term health and quality of life of an individual.

### **IV. CONCLUSION**

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<sup>20</sup> World Health Organization (WHO), *World Report on Disability*, Ch. 4: 95-7, (2011), available at [http://www.who.int/disabilities/world\\_report/2011/report.pdf](http://www.who.int/disabilities/world_report/2011/report.pdf) [emphasis added].

AOTA requests that HHS include “maintenance of function” in the definition of “habilitative services” for purposes of EHB and set a benefit floor for the health insurance purchasing exchanges through notice-and-comment rulemaking rather than by relinquishing the issue to states. AOTA finds that the advantages of coverage for maintenance care furnished by qualified practitioners far outweighs any disadvantages and would protect children and persons with disabilities for whom habilitative care is necessary and fundamental; promote evidence-based, high quality, cost-effective care; advance ACA goals; and provide consistency across programs and reliability for consumers as they change insurers and navigate plans. Should you have any questions or require additional information, please contact us at (301) 652-6611 ext. 2023 or [jhitchon@aota.org](mailto:jhitchon@aota.org). AOTA looks forward to a continuing dialogue with HHS – specifically, CCIIO – regarding health coverage and other issues that impact the ability of occupational therapy practitioners to provide high quality, cost effective care to their patients.

Respectfully submitted,

A handwritten signature in cursive script that reads "Jennifer Hitchon". The signature is written in black ink and is positioned above a horizontal line.

Jennifer Hitchon  
*Regulatory Counsel*