[Submitted Electronically]

April 20, 2017

Re: Access to Rehabilitation Services and Devices under the American Health Care Act

Dear Member of Congress:

The undersigned organizations write as members of the Coalition to Preserve Rehabilitation (CPR) to express our deep concern about repealing key provisions of the Affordable Care Act (ACA) that would limit access to rehabilitation services and devices—one of ten statutory essential health benefits (EHBs)—for children and adults in Medicaid expansion states, as well as private ACA health plans. CPR is a coalition of forty-seven (47) 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.

We stress the importance of maintaining access to rehabilitation services and devices in any ACA repeal and replace bill that advances in the House and Senate. The American Health Care Act (AHCA), H.R. 1628 as amended, includes a provision that repealed the EHB package for Medicaid expansion enrollees. The bill also modified the actuarial value requirements of the EHB package under ACA private plans. CPR was alarmed by these proposals because they undercut the federal coverage standard for rehabilitation benefits responsible for a dramatic increase in access to these benefits for beneficiaries and enrollees across the country.

CPR continues to have significant concerns with the AHCA, in addition to the most recent proposals under discussion to further amend the AHCA, that include: 1) a repeal of the EHB package for Medicaid expansion enrollees; 2) allowing states to waive requirements for private plans to cover EHB and delegating to states the determination of the scope of essential health benefits; and 3) allowing states to waive the requirement for community rating which would dramatically impact those with pre-existing conditions. There is little doubt under this scenario that access to rehabilitation services and devices will suffer in many areas of the country. Americans needing rehabilitation services and devices rely on their health care coverage to regain and/or maintain their maximum level of health, independent function, and independent living. This reduces long-term disability and dependency costs to society.

Essential health benefits protects all patients by ensuring they have basic coverage; by eliminating the benefit standards, this likely will lead to insurers offering inadequate plans that fail to cover important

services, thus resulting in patients who are underinsured and unable to access rehabilitative services and devices. Many individuals and families who have not yet experienced a major illness or injury simply do not understand how critical rehabilitation coverage is to recovery, improvement of function, and maintenance of health. At the time of an acute injury or illness, the first thought is survival and acute care. Inexperience with major illness or injury should not leave families with wholly unmet rehabilitation needs when they are already dealing with an onslaught of medical information, expenses, and uncertainty about the future.

Another proposal being discussed is letting states waive the requirement for community rating. This would allow the insurance companies to charge premiums that could make coverage unaffordable for many people with disabilities and chronic conditions—including people needing rehabilitation—which would make pre-existing condition protections essentially meaningless. The combination of these changes could dramatically reduce access to rehabilitation services and devices for millions of Americans who currently have this coverage.

For these reasons, CPR strongly urges Congress to maintain the federal standard for EHB coverage, specifically, coverage of rehabilitative services and devices, and to maintain the federal requirement for community rating in any ACA repeal and replace legislation that is advanced in the future.

I. Definition of Rehabilitation Services and Devices

The ACA created in statute the Essential Health Benefits (EHB) category of "rehabilitative and habilitative services and devices." ACA, Section 1302 (b). In the February 2015 Benefit and Payment Parameters Final Rule, the Centers for Medicare and Medicaid Services (CMS) defined "rehabilitation services and devices" using the definition of "rehabilitation services" from the National Association of Insurance Commissioners' *Glossary of Health Coverage and Medical Terms*[1] plus explicitly adding rehabilitation 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."[2]

This definition is a floor for individual insurance plans sold under the ACA exchanges. It was also adopted by states that chose to expand their Medicaid programs. For the first time, this definition established a uniform, understandable federal definition of rehabilitation services and devices that became a standard for national insurance coverage. We stress that this definition is a floor for coverage and includes both rehabilitative *services* and rehabilitative *devices*. The services and devices covered by the rehabilitation benefit should not be limited to the therapies enumerated in the federal regulation which are listed as *examples* of covered benefits.

CPR supports the preservation of the EHB category of "rehabilitative and habilitative services and devices," and the subsequent regulatory definition and related interpretations duly promulgated, as a standard of coverage for rehabilitation under any version of ACA replacement legislation. CPR

[1] https://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf.
[2] http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf, at 10811.

believes that adopting the uniform federal definition of rehabilitation services and devices minimizes the variability in benefits across states and uncertainty in coverage for children and adults in need of rehabilitation.

In addition to the regulatory definition cited above, examples of these types of services typically provided under this benefit include rehabilitation medicine, behavioral health services, recreational therapy, developmental pediatrics, cardiac and pulmonary rehabilitation, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings. These services should be provided based on the individual's needs, prescribed in consultation with a clinician, and based on the assessment of an interdisciplinary team and resulting care plan.

II. Examples of Rehabilitation

The vignettes below help to demonstrate the value of rehabilitation:

Rehabilitation Following a Traumatic Brain Injury
Jason is a 43-year-old computer systems administrator. Following a bicycle accident in April 2014, Jason was diagnosed with a traumatic brain injury. Through an intensive team-based rehabilitation process, he was able to transition from total loss of motor skills, speech and memory, resuming full function in his previous roles. He is now able to care for his ten children, drive, and return to work.

Rehabilitation Following Spinal Cord Injury
Cayden is a 15-year-old high school student. Following a car accident in January 2016, he was diagnosed with a spinal cord injury causing paralysis in his arms and legs. With intensive rehabilitation from a multidisciplinary team of medical professionals, including physical and occupational therapists, he was able to regain balance and arm/hand function. He is now able to walk unassisted and drive, and has returned to school.

Lisa is a 58-year-old elementary school teacher. Following a horseback riding accident, Lisa was diagnosed with a spinal cord injury causing paralysis in her upper and lower extremities. With intensive rehabilitation, she no longer needed a wheelchair or support at home, and she significantly improved left leg function. She is now able to live independently and can walk with a quad cane. Intensive rehabilitation continues to build strength and endurance. In the longer term, Lisa may need rehabilitation devices such as a wheelchair or other mobility devices that enable her to maintain her productivity, community participation, and the capacity to age in place.

Rehabilitation Following a Stroke
David is a 54-year-old man who suffered a cerebrovascular accident, or stroke, that resulted in cognitive deficits, including impaired attention and memory, executive function deficits, and social pragmatic communication deficits. As a result of this acquired brain injury, he lost his ability to function at work and at home. A speech-language pathologist (SLP) evaluated David's speech, language and cognitive abilities using standardized testing to determine how his deficits affect his cognitive function and job performance. The interprofessional team established a plan of care to improve and maximize David's cognitive functioning, with the goal of returning him to his previous job, though with modified duties. Interdisciplinary collaboration ensures that David's multiple needs are met and coordinated among providers, including the psychologist and physician. The SLP focuses treatment on using existing cognitive strengths to implement compensatory strategies that address deficit areas. After rehabilitation he successfully transitioned to his modified job duties.

Ed is a 50-year old high school volleyball and basketball coach. In September 2013, two strokes left him with a paralyzed left arm and leg. With intensive rehabilitation, he no longer depended on a wheelchair, and improved his balance, leg and arm function. He is now able to walk unassisted and dance, and has returned to coaching.

Rehabilitation for Patients with Multiple Sclerosis

Joan is a 38-year-old accountant who was diagnosed with multiple sclerosis (MS) when she was 33. She has experienced relapses about every few months since then, with slowly advancing disability. While she is able to walk with a cane, she experiences painful flexor spasms which make it difficult for her to concentrate, perform household activities and concentrate at work. In addition, she experiences severe fatigue that peaks around mid-afternoon. Because of these symptoms she was seriously considering retiring on disability. Six months ago, she began regular sessions with a physical therapist (PT) and an occupational therapist (OT). Her PT taught her stretching exercises, movement strategies, and energy conservation techniques that were individualized to improve her movement, taking into consideration her MS diagnosis. Through occupational therapy, she learned to adjust her activity routines and responsibilities to capitalize on her periods of optimal performance and manage her fatigue. Her rehabilitation program helped her to decrease spasms, improve efficiency with movement, and manage her activities to decrease her fatigue. As a result, she is able to put in a full and productive work day and participate in community activities.

When Rehabilitation Coverage is Not Available

John is a 19-year old community college student who was shot as an innocent bystander on his street and became paralyzed and insensate from the neck down. John is a Medicaid recipient and was referred by the trauma center for inpatient rehabilitation, knowing he would need extensive rehabilitation services and devices, including the use of a powered wheelchair for mobility. However, because his Medicaid coverage did not cover inpatient hospital rehabilitation or powered wheelchairs, John was placed in a long-term nursing home where he would remain indefinitely. At the long-term nursing home, John has no access to the expert rehabilitation and habilitation therapy that he needs to build the functional capacity to return to school and his community. This young man's future as an independent taxpayer and full member of society is now uncertain.

III. Compliance with *Jimmo v. Sebelius*

For all rehabilitative services and devices, CPR recommends that any reform of the Affordable Care Act be modeled after the recent *Jimmo v. Sebelius* decision, i.e., that Medicare coverage is available for skilled services to maintain an individual's function, not only to improve it. Pursuant to *Jimmo*, medically necessary nursing and therapy services, provided by or under the supervision of skilled personnel, are covered services by Medicare if the services are needed to maintain the individual's condition, or prevent or slow their decline. CPR recommends that any legislation reforming the Affordable Care Act's essential health benefits make explicitly clear that a patient need not demonstrate improvement in order for skilled services to be covered as reasonable and necessary.

IV. Conclusion

Each of the vignettes cited above represent real-life instances where access to rehabilitation services and devices has maximized the health, function, and independence of those who have been able to access these services. **The undersigned members of CPR firmly believe that failing to replace the Affordable Care Act in a manner that would preserve access to rehabilitative services and devices would turn back the clock on children and adults with injuries, illnesses, disabilities and chronic conditions.**

Thank you for your willingness to consider our views. Should you have further questions regarding this information, please contact Peter Thomas or Steve Postal, CPR staff, by emailing Peter.Thomas@powerslaw.com or Steve.Postal@powerslaw.com, or by calling 202-466-6550.

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Sincerely,

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Supporting Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Heart Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Association of University Centers on Disabilities
Association of Rehabilitation Nurses
Brain Injury Association of America
Center for Medicare Advocacy
Child Neurology Foundation
Child Neurology Society
Child Welfare League of America
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
Easterseals
Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
Lupus Foundation of America
The Michael J. Fox Foundation for Parkinson's Research
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Council for Behavioral Health
National Council on Independent Living
National Disability Rights Network
National Multiple Sclerosis Society
National Rehabilitation Association
Paralyzed Veterans of America
Rehabilitation Engineering and Assistive Technology Society of North America
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association