January 27, 2022

ELECTRONIC SUBMISSION VIA www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: HHS Notice of Benefit and Payment Parameters for 2023 (CMS-9911-P; RIN: 0938-AU65)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2023 (NBPP)[1]. Given the importance of this annual rulemaking, and the significant impact the NBPP regulations have on enrollees in the exchanges, we urge CMS to establish at least a 60-day comment period to ensure that stakeholders and advocates are able to appropriately consider and respond to provisions in future proposed rules.

CPR is a coalition of 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. CPR is comprised of organizations that represent patients – as well as the clinicians who serve them – who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

I. Rehabilitative Services and Devices under the ACA

The Affordable Care Act (ACA) includes statutory language that requires coverage of essential health benefits (EHBs), including one of ten categories of benefits known as "rehabilitative and habilitative services and devices." Inclusion of this language in the statute was a major milestone for the rehabilitation and disability community, in that Congress recognized the importance of these benefits to improve the health and functioning of the American people.

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584 (Jan. 5, 2022).

In the NBPP final rule for 2016[2], CMS defined "rehabilitation services and 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."

For the first time, this regulation established a uniform definition of rehabilitative services and devices that states and health plans could understand and consistently implement. This definition became a standard for private insurance coverage and a floor of coverage for individual insurance plans sold on the exchanges. Importantly, the definition includes both rehabilitative services and rehabilitative devices. The adoption of a federal definition of rehabilitation services and devices minimized the variability in benefits across states and uncertainty in coverage for children and adults in need of medical rehabilitation and post-acute care. The rehabilitation and habilitation benefits under the ACA have been critical to ensuring that individuals with injuries, illnesses, disabilities, and chronic conditions are able to access the care they need. We appreciate the agency's commitment to maintaining these benefits and supporting enrollees in this proposed rule.

II. Ensuring Meaningful Network Adequacy

In the rule, CMS proposes to codify new standards and methodologies to evaluate network adequacy for qualified health plans (QHPs) in the federally facilitated exchanges (FFEs). The adequacy of a plan's provider network can greatly impact the level of access to benefits for enrollees. For individuals enrolled in a QHP to benefit from appropriate rehabilitation, CPR believes that issuers must adhere to patient-friendly network adequacy standards that provide ample access to the full complement of rehabilitation and habilitation service and device providers, professionals, and facilities that provide both primary and specialty care. These services should be provided based on the individual's needs, prescribed in consultation with an appropriately credentialed clinician, and based on an assessment by an interdisciplinary rehabilitation team and a resulting plan of care.

CMS proposes to codify the list of provider and facility specialty types subject to the network adequacy reviews. CMS does *not* propose to include post-acute rehabilitation programs, such as inpatient rehabilitation hospitals and units (IRFs), comprehensive outpatient rehabilitation facilities (CORFs), or long-term care hospitals (LTCHs) in the list of facility specialty types evaluated during these reviews. These are critical settings of care for rehabilitation services and devices and their omission in network adequacy reviews is a glaring omission in this proposed rule. This is illustrated by the fact that CMS includes IRFs and CORFs as a covered benefit under traditional Medicare, and hundreds of thousands of Medicare enrollees benefit from treatment from these providers on an annual basis. **CPR strongly urges CMS to include IRFs, CORFs, and LTCHs as part of the agency's network adequacy review process**.

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10749 (Feb. 27, 2015).

Ensuring the availability of a wide range of rehabilitation provider types will help ensure that enrollees have access to the appropriate intensity and scope of needed rehabilitation services. For instance, too often enrollees across the country may be diverted into nursing homes rather than IRFs because their health plans do not contract with a sufficient number of rehabilitation providers. Too often, enrollees with brain injuries, spinal cord injuries, those who have sustained strokes, and others with a variety of complex but common conditions do not receive the intensive, longer-term services they need because health plans do not contract with specialized brain treatment programs. Further, inadequate specialty networks exacerbate health equity issues for patients who are already facing disparities in access to health care.

CMS also proposes to set maximum time and distance standards for the providers and facility specialty types subject to network adequacy standards. **Network adequacy standards should ensure that people with injuries, illnesses, disabilities, and chronic or complex conditions are not burdened by significant traveling distances in order to receive covered services under the plan and should recognize that many people with disabilities lack transportation options**.

III. Network Adequacy and Telehealth

CMS proposes to require all issuers seeking certifications of plans to submit information about whether network providers offer telehealth services. The agency states that this data would not be made public and would be intended for information purposes only. In the Medicare Advantage program, CMS has allowed MA organizations to receive a "credit" towards the percentage of enrolled beneficiaries residing within the applicable time and distance to meet network adequacy standards, if the MA organization contracts with telehealth providers for certain specialties. While CMS clearly states in this rule that the agency is *not* proposing such a policy for plan year 2023, the rule does seek comment on whether the network adequacy standards for exchange plans and MA plans should be aligned, particularly citing the telehealth credit approach used in the MA program.

CPR appreciates that the rapid expansion of telehealth during the COVID-19 pandemic has allowed many beneficiaries, whether covered through the exchanges, Medicare, Medicaid, or other payers, to safely access medically necessary health care while protecting themselves from threat of infection with COVID-19. Further, the ability to receive medical services, including medical rehabilitation, virtually has provided tremendous benefit to many people with disabilities beyond abiding by social distancing protocols, including easing the complications associated with planning, transportation, and accessibility of in-person visits and the potential to cut down on distractions and hurdles associated with receiving care in an unfamiliar environment. We also note that the proliferation of telehealth may allow patients to receive more stable, continuing access to therapy and other important services. **We support increased access to care through the use of telehealth, as long as it does not come at the expense of providing face-to-face health care services when in-person services are necessary, preferred by the patient, or would enhance the quality of care to people with disabilities.**

It is critical that expansion of telehealth services, and policies encouraging such expansion, does not limit patients' access to in-person care, especially when the services needed by the patient are more effectively and efficiently provided in-person. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions often need the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is crucial that beneficiaries receiving rehabilitation care are able to access the most appropriate care in the most appropriate settings.

People with disabilities should have access to disability-specific specialists and services, in settings that are physically accessible, and with a choice of providers – primary, specialty, and subspecialty. CPR believes that the adequacy of a plan's provider network dictates the level of access to benefits otherwise covered under the health plan. If a plan covers a benefit but limits the number of providers or specialists under that plan, coverage will be curtailed through a lack of access to providers with sufficient expertise to treat the patient. In light of these concerns, CMS must ensure robust network adequacy standards that fully protect access to both in-person and virtual care – and these standards must be strictly enforced. It is essential that Americans have access to affordable and meaningful coverage of rehabilitative services and devices to which they are entitled.

IV. Promoting Broader Use of Rehabilitation and Habilitation Modifiers

Beginning in 2017, the ACA mandated all individual and small-group, non-grandfathered health plans that utilize visit limits to have separate limits for rehabilitative and habilitative services.[3] This requirement is critical to ensuring that enrollees have sufficient access to both benefits, which may incorporate similar services but are distinct in therapeutic purpose. To appropriately administer the separate visit limits, clinicians and plans need to identify whether a provided service is rehabilitative or habilitative.

In 2017, the most common method for tracking habilitative services was through the -SZ modifier, which is added to the corresponding Current Procedural Terminology (CPT) code on the claim form. However, there was no mechanism for clinicians to indicate a rehabilitative service, leaving health insurance plans to make assumptions about the nature of the services when a modifier is not included. To alleviate the potential for confusion, stakeholders worked to create new CPT modifiers to accurately reflect the type of services provided by therapy professionals.

Two new modifiers and descriptions were added in Appendix A of the 2018 CPT code book[4] and can be added to the appropriate CPT codes on claims submitted to ACA-compliant and other health insurance plans:

- **96, habilitative services:** "When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative

[3] 2016 NBPP at 80 FR 10811.
[4] © American Medical Association.

services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

- **97, rehabilitative services:** "When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled."

The American Medical Association created these new modifiers through the CPT system. They do ***not*** replace the -SZ modifier (habilitative services) developed by CMS and used by many non-Medicare payers. **CPR encourages CMS to develop policies, whether through the final NBPP for 2023, other regulations, or subregulatory guidance, to encourage use of these CPT modifiers for rehabilitative and habilitative services by all qualified health plans (QHPs) participating in the exchanges**. **Furthermore, CMS should collect and make publicly available data on the services provided in these benefits identified by the modifiers, in order to better ascertain the availability of these services and any potential barriers to access or imbalances between coverage of rehabilitation and habilitation services**.

Better data collection, made available to stakeholders and the public, will illuminate whether future policy changes must be made to protect access to these services, including to ensure that the requirement for separate limits on rehabilitation and habilitation services is being followed. In keeping with the Department's focus on evidence-based practice, future regulations governing the rehabilitation benefit must rest upon a strong foundation of data, which can be bolstered with the improved use of the rehabilitation and habilitation modifiers.

V. Use of Evidence-Based Standards

CMS proposes to refine the EHB non-discrimination policy to "ensure that benefit designs, and ***particularly benefit limitations*** and plan coverage requirements, are based on clinical evidence." [Emphasis added.] CMS proposes to define appropriate evidence to include peer-reviewed articles in medical journals, clinical practice guidelines, and recommendations from reputable governing bodies. **We greatly appreciate the focus on preventing discriminatory benefit limitations and encourage CMS to emphasize that these new requirements should not be used to deny coverage for treatments**. Instead, plans that impose restrictions such as visit limits and caps for rehabilitation therapy should be required to present sufficient clinical evidence to justify these constraints, protecting enrollee's access to care.

Rehabilitation is a particularly complex field, with wide variations in complexity and outcomes even within seemingly narrowly defined conditions. In many cases, it is difficult to develop a gold standard of clinical evidence for rehabilitation through double-blinded studies and clinical trials, which in some cases raise ethical concerns. For example, a 2012 report from the Agency

for Healthcare Research and Quality (AHRQ)[5] on rehabilitation for traumatic brain injury (TBI) found that comparative effectiveness research on TBI rehabilitation was limited but noted that the "failure to draw broad conclusions must not be misunderstood to be evidence of ineffectiveness." Further, the study authors contended that rigorously conducted systematic reviews, the "gold standard" of clinical evidence, represent a "high bar currently met by only a small portion of medical interventions (and an even smaller portion of rehabilitation interventions.)"

The proposed rule's call for evidence-based benefit coverage must not be interpreted by plans to create an overly rigid evidentiary standard. If this regulatory language is deployed inappropriately, it may limit beneficiary access to care, especially with respect to complex, chronic, or uncommon conditions that may not have a wide range of high-quality evidence supporting particular courses of treatment. We recognize the importance of CMS' protections against discriminatory benefit design, and on behalf of the rehabilitation community, encourage the agency to protect patients' access to the essential benefits to which they are entitled.

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We greatly appreciate your consideration of our comments on the 2023 Notice of Benefit and Payment Parameters proposed rule. Should you have any further questions, please contact Peter Thomas and Joe Nahra, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Association on Health and Disability
American Congress of Rehabilitation Medicine
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 Rehabilitation Nurses
Association of University Centers on Disabilities

[5] Brasure M, Lamberty GJ, Sayer NA, et. al. Multidisciplinary Post-Acute Rehabilitation for Moderate to Severe Traumatic Brain Injury in Adults. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2007-10064-I.) AHRQ Publication No. 12-EHC101-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2012. www.effectivehealthcare.ahrq.gv/reports/final.cfm.

Brain Injury Association of America*
Center for Medicare Advocacy*
Christopher & Dana Reeve Foundation*
Disability Rights Education and Defense Fund
Falling Forward Foundation*
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers (NASW)
National Association of State Head Injury Administrators
National Disability Rights Network (NDRN)
National Multiple Sclerosis Society*
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
United Cerebral Palsy
United Spinal Association*

**** CPR Steering Committee Member***

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Administrator
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7500 Security Boulevard
Baltimore, MD 21244

RE: HHS Notice of Benefit and Payment Parameters for 2023 (CMS-9911-P; RIN: 0938-AU65)

Dear Administrator Brooks-LaSure:

The undersigned members of the Habilitation Benefits (HAB) Coalition appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule for the 2023 Notice of Benefit and Payment Parameters[1] (NBPP). We support many of the provisions in the NBPP for their positive impact on individuals in need of habilitative services and devices. At the same time, given the importance of this proposed annual rule, we urge CMS in the future to establish a comment deadline of at least 60 days so that stakeholders may fully consider and respond to the critical issues raised in this proposed rule.

The HAB Coalition membership includes national non-profit consumer and clinical organizations focused on securing and maintaining appropriate access to, and coverage of, habilitation benefits within the category known as "rehabilitative and habilitative services and devices" in the essential health benefits (EHB) package under the Patient Protection and Affordable Care Act (ACA), Section 1302. The HAB Coalition has worked hard over the past several years with the ultimate goal of eliminating decision-making based on health status in the individual and small group markets, which disproportionately impacts people with disabilities and chronic conditions.

The 2023 proposed NBPP sets forth benefit and payment parameters, updates EHB benchmark plan policies, revises nondiscrimination protections, proposes new requirements for standardized plan offerings, and proposes many other new policies regarding implementation of the ACA. This comment letter will focus on key proposed provisions relating to enrollees in need of habilitative services and devices, one of the categories of essential health benefits under the ACA.

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584 (Jan. 5, 2022).

I. Habilitative Services and Devices under the Affordable Care Act

Habilitation services and devices are provided by appropriately credentialed (licensed, accredited, and certified) providers to individuals with many types of developmental, cognitive, physical, and mental conditions that, in the absence of such services, prevent those individuals from acquiring certain skills and functions over the course of their lives. Habilitation services are closely related to rehabilitation services, although there are key differences between the two. Whereas *rehabilitation services* are provided to help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition, *habilitation services* are provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

Habilitation services and devices include, but are not limited to, physician services; physical therapy; occupational therapy; speech, language, and hearing therapies; recreational therapy; music therapy and cognitive therapy for people with brain injuries and other conditions; psychiatric, behavioral, and other developmental services and supports; durable medical equipment (DME), including complex rehabilitation technologies; orthotics and prosthetics; low vision aids; hearing aids, cochlear implants, and augmentative communication devices; and other assistive technology and supplies. Habilitation services:

- Improve long-term function and health status and improve the likelihood of independent living and quality of life;
- Halt or slow the progression of primary disabilities by maintaining function and preventing further deterioration of function;
- Enable persons with developmental, intellectual, physical, or cognitive impairments to improve cognition and functioning through appropriate therapies and assistive devices.

Prior to the ACA, most private health plans did not cover habilitative services and devices and only three states (Illinois, Maryland, and Oregon) had adopted a habilitative services coverage mandate in the individual market. Not only did this dramatically impact access to and quality of care for children and adults in need of these services and devices, but a lack of coverage also contributed to significant downstream costs to the health care system for unnecessary disability and dependency. Therefore, coverage gains for habilitative services and devices were hard fought but necessary to meet the needs of a wide variety of children and adults with autism, cerebral palsy, congenital deficits, disabilities, and other chronic and progressive conditions.

The category of "rehabilitative and habilitative services and devices" was included in the ACA as an essential health benefit, one of ten essential categories of benefits that must be covered by ACA health plans. It is noteworthy that Congress chose to include a separate EHB category for rehabilitative and habilitative services and devices to specifically list in the statute in recognition of the important role the benefit plays in helping ensure that adults and children maximize their health, function, ability to live independently, and participation in society. In the 2016 Notice of

Benefit and Payment Parameters Final Rule[2], CMS defined "habilitation services and devices" as follows:

> "Habilitative services and devices – Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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."

For the first time, this definition established a uniform, understandable federal definition of habilitation services and devices that became a standard for national insurance coverage. The inclusion in the ACA of the category of rehabilitative and habilitative services and devices was a major milestone for the disability community, in that Congress recognized the importance of these benefits to improve the health and functioning of the American people, regardless of the diagnosis or reason for one's functional impairment. The federal coverage standard for habilitation benefits has been responsible for a dramatic increase in access to these important benefits for patients across the country.

II. Changes to the EHB Benchmark Selection Process

The Department proposes to withdraw the state option to substitute benefits between EHB categories, a flexibility that was initially provided in the 2019 NBPP final rule.[3] The HAB Coalition has called on the Department in the past to remove this option, believing that it could allow states to select a more limited benefit package and thus discourage the enrollment of high-need individuals. As noted in the rule, no state has permitted issuers to substitute benefits between EHB categories, and therefore, this aspect of the regulation has not provided the increased flexibility, consumer choice, and plan innovation that was identified as the justification for this option. We appreciate that HHS recognizes the potential harm to individuals with chronic conditions and disabilities that this flexibility could create, and we strongly support this proposal to remove the substitution pathway.

We support the proposal to create an "evergreen" annual deadline for EHB-benchmark submissions. Identifying a consistent date for these updates will increase reliability for states and stakeholders who are closely watching changes to the benchmark selections. Further, while we recognize that the option to modify benchmark submissions remains in place, we encourage the Department to remain vigilant that any changes in a state's benchmark plan do not result in a decreased availability of essential benefits. Through the ACA, individuals and families have come to rely on coverage of habilitation services and devices by their plans. Any change in the benchmark allowed through this flexibility could have a significant impact on individuals who

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10749 (Feb. 27, 2015).

[3] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (Apr 17, 2018).

have a disability or chronic condition and require habilitation services and devices to improve, maintain, or prevent the loss of their health and functional ability.

To fully ensure that high-quality health care is affordable and accessible for everyone, we urge CMS to collect and report data on states that utilize this flexibility. We recognize that states must undergo a public comment period for their own proposals to change benchmark plans, but standardized data and analysis by CMS would allow consumers, advocates, and other stakeholders to better identify and understand any trends that may arise that could benefit or harm individuals covered through the Exchanges.

III. Promoting Broader Use of Habilitation and Rehabilitation Modifiers

Starting in 2017, the ACA mandated all individual and small-group, non-grandfathered health plans that utilize visit limits to have separate limits for habilitative and rehabilitative services, which the HAB Coalition strongly supported to ensure sufficient coverage of and access to both benefits.[4] To appropriately administer the separate visit limits, clinicians need to identify whether a provided service is habilitative or rehabilitative.

In 2017, the most common method for tracking habilitative services was through the -SZ modifier, which is added to the corresponding Current Procedural Terminology (CPT) code on the claim form. However, there was no mechanism for clinicians to indicate a rehabilitative service, leaving health insurance plans to make assumptions about the nature of the services when a modifier is not included. To alleviate the potential for confusion, stakeholders including the American Speech-Language Hearing Association (ASHA, a HAB Coalition Steering Committee member) worked to create new CPT modifiers to accurately reflect the type of services provided by therapy professionals.

Two new modifiers and descriptions were added in Appendix A of the 2018 CPT code book[5] and can be added to the appropriate CPT codes on claims submitted to ACA-compliant and other health insurance plans:

- **96, habilitative services:** "When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.
- **97, rehabilitative services:** "When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative

[4] 2016 NBPP at 80 FR 10811.

[5] © American Medical Association.

services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled."

The American Medical Association created these new modifiers through the CPT system. They do ***not*** replace the -SZ modifier (habilitative services) developed by CMS and used by many non-Medicare payers. The HAB Coalition recommends that CMS consider policies, whether implemented through the final NBPP, other regulations, or subregulatory guidance, to encourage use of these CPT modifiers for habilitation and rehabilitation services (96 and 97, respectively) by all qualified health plans (QHPs) participating in the Exchanges. Furthermore, CMS should collect and make publicly available data on the services provided in these benefits identified by the modifiers, in order to better ascertain the availability of these services and any potential barriers to access or imbalances between coverage of rehabilitation and habilitation services. As clarified in the 2016 NBPP final rule, plans cannot impose any limits on habilitation that are less favorable than those imposed on rehabilitation. Unfortunately, a lack of robust data on the provision of these benefits makes it difficult to confirm to what extent this requirement is being followed.

Better data collection, made available to stakeholders and the public, will also illuminate whether future policy changes must be made to protect access to these services, including to ensure that the requirement for separate limits on rehabilitation and habilitation services is being followed. Further, we have also identified a need for any caps, if used, to be applied per condition or episode of care, rather than tied to a specific time period, such as a calendar year. This would ensure that patients with multiple co-occurring or unrelated conditions will be able to access sufficient therapy.

In keeping with the Department's focus on evidence-based practice, future regulations governing the habilitation benefit must rest upon a strong foundation of data, which can be bolstered with the improved use of the habilitation and rehabilitation modifiers.

IV. Ensuring Meaningful Network Adequacy

The HAB Coalition appreciates the Department's focus on network adequacy in the 2023 proposed rule, and we agree with HHS' view that strong network adequacy standards are necessary to achieve greater equity in health care and to enhance consumer access to quality, affordable care. As the Department considers network adequacy reviews and requirements applicable to QHPs in 2023 and beyond, we urge the Department to ensure that networks provide sufficient and stable access to habilitation services and providers. We offer more detailed comments below.

Application of Time and Distance Standards

In general, we recognize the need to develop time and distance standards as a method to evaluate network adequacy in QHPs operating on the Exchanges. Any assessment of network breadth should be broad enough to account for the medical needs of enrollees residing in rural areas, as well as children and adults with disabilities and complex or chronic conditions. Network

adequacy standards should ensure that those in need of habilitation services are not burdened by significant traveling distances or logistics in order to receive covered services under the plan.

Furthermore, we note that time and distance standards should not always be used as the sole measure of network breadth, given shortages of some types of providers and the ongoing regionalization of some specialty care. For example, those standards do not appropriately account for children with medical complexity or other special health care needs who must travel long distances to receive care, including habilitative services, at children's hospitals, which serve large geographic areas. One study[6] found that nearly half of pediatric specialty hospitalizations took place outside of adult-focused distance standards. Similarly, an analysis[7] by the Children's Hospital Association found that approximately 50% of children nationwide would not have access to the services of an acute care children's hospital if adult Medicare Advantage time and distance standards are used.

We urge CMS to develop and adopt a network adequacy standard that requires health plans to have a full range of adult and pediatric providers in-network capable of providing all covered services, from preventive care to the most complex care. Networks should also be required to contract with specialists (adult and pediatric), and those that provide specialized habilitation and rehabilitation services specifically, without additional cost-sharing burden levied on consumers.

Specialty Lists for Adequacy Standards

CMS proposes to adopt the time and distance standards outlined above to a specified list of provider specialties and facility types. As noted in the proposed rule, these lists cover more provider types than were previously evaluated in the Exchanges, so that networks will be "more robust, more comprehensive, and more responsive" to enrollee's needs. The HAB Coalition particularly appreciates the inclusion of several specialties that frequently provide habilitation services, including physical medicine and rehabilitation, occupational therapy, physical therapy, and speech therapy. We encourage CMS to include audiology in this list as well. Audiologists play a critical role in habilitation for individuals with hearing and related disorders, working individually and/or with other specialties to enhance their overall health status, independence, and quality of life.

Furthermore, we note that several settings where habilitation and rehabilitation services are frequently provided are not included in the proposed facility specialty list for the time and distance standards. In particular, inpatient rehabilitation facilities (IRFs), comprehensive outpatient rehabilitation facilities (CORFs), and long-term care hospitals (LTCHs) are omitted,

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[6] Colvin, J., et. al. *Hypothetical Network Adequacy Schemes for Children Fail to Ensure Patients' Access to In-Network Children's Hospital*, Health Affairs 37, No. 6 (June 2018): 873-880. Doi: 10.1377/hlthaff.2017.1339,

[7] *An Examination of Certain Network Adequacy Measures and their Potential Impact on Children's Access to a Children's Hospital*, Children's Hospital Association, December 2014. Available at: https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Exchanges_and_Private_Coverage/Issue-Briefs-and-Reports/Capacity_of_Childrens_Hospitals_Dec2014.pdf

though skilled nursing facilities (SNFs) are included. We encourage CMS to add these facilities to the list to ensure that QHP enrollees have adequate access to these critical settings of care.

We also note that CMS proposes to adopt appointment waiting time standards for a short list of services, namely behavioral health services, routine primary care, and non-urgent specialty care. We encourage CMS to require QHP issuers to collect data on the average time it takes for their enrollees to secure an appointment with each of their network's providers across specialties. This data would help provide a clearer picture of any barriers to access that certain populations face and help determine whether future expansion of wait time standards or other corrective action is necessary.

Telehealth

HHS proposes to newly require all QHP insurers to submit information about whether network providers offer telehealth services. HHS clearly notes that this data would be used for informational purposes only in plan year 2023; it would not be shared with consumers and would be intended to help inform future policy development. The rule clearly states that for the coming plan year, "insurers should not construe this proposal to mean that telehealth services could be counted in place of in-person service access for the purpose of network adequacy standards." However, HHS then seeks comment specifically on whether future standards for Exchange plans should offer a credit towards meeting time and distance standards for issuers offering telehealth services.

Telehealth services and the provision of virtual care, especially during the ongoing public health emergency, have in many cases been extremely beneficial to individuals with disabilities, illnesses, injuries, and complex or chronic conditions. The ability to receive health care remotely, including some habilitation services, helps patients avoid time-intensive, taxing, and potentially costly travel to and from appointments, allows individuals to receive care in their home and often more independently, and in some cases, provides even greater clinical benefit than some in-person services. The HAB Coalition strongly supports increased access to care through the use of telehealth.

It is critical, however, that the continued expansion of telehealth does not come at the expense of providing quality care to patients, especially those in need of habilitation and rehabilitation services. While many individuals may see great benefit, and may even prefer receiving telehealth services, not all conditions can be appropriately treated remotely. Decisions about the most effective modality of care, including consideration of individual patient circumstances, should be made between the individual receiving care, their provider, and their caregiver(s), if applicable. CMS regulations, and health plans' policies, should not intentionally or unintentionally push individuals to receive telehealth when in-person care is needed. By extension, CMS should not weaken access to in-person care by treating telehealth as a perfect substitute. We urge the agency to maintain robust network adequacy standards in 2023 and future years that both encourage the availability of telehealth *and* protect access to in-person care.

V. Prohibiting Discrimination and Promoting Equity

Given historic patterns of discriminatory benefit plan design in the area of habilitative services and devices, we appreciate CMS' focus on the importance of nondiscrimination provisions in this year's proposed rule. As noted in the preamble of the proposed rule, the ACA requires that benefit design not discriminate against individuals because of their age or disability[8], and there are numerous legal protections in the ACA that are designed to ensure fairness and equity in the benefit design of the EHB package.

For instance, a habilitation services benefit that arbitrarily limits visits to 20 or 30 visits per year or per condition, by definition, provides inequitable coverage to individuals with more complex conditions such as brain injuries or developmental disabilities, than those with conditions that require much less habilitative intervention. The proposed rule emphasizes the importance of evidence-based medicine in establishing EHB benefits, which can be a double-edged sword. But in this instance, where insufficient evidence exists to limit habilitation benefits for individuals with extensive needs, plans should be required to make exceptions to coverage that promote more equitable access to care.

In addition, we strongly agree with CMS' proposal to reinstate the full slate of protections against discrimination in the ACA regulations, including protection against discrimination based on sexual orientation or gender identity. Unfortunately, like those with disabilities and chronic conditions, LGBTQI+ individuals have often faced significant barriers to accessing health care. We encourage the agency to finalize this portion of the proposed rule and hope that these barriers will be lifted, including for habilitation services, such as speech therapy, that may be prescribed for individuals undergoing gender affirmation processes.

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We greatly appreciate your attention to our comments on this proposal. Should you have further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for the HAB Coalition, by e-mailing Peter.Thomas@PowersLaw.com or Joseph.Nahra@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Habilitation Benefits Coalition

ACCSES
American Academy of Physical Medicine & Rehabilitation
American Association on Health and Disability
American Cochlear Implant Alliance
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(4)(B) (2010).

American Speech-Language-Hearing Association
American Therapeutic Recreation Association
The Arc of the United States
Brain Injury Association of America
Children's Hospital Association
Christopher & Dana Reeve Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics & Prosthetics
National Association of Social Workers (NASW)
United Spinal Association