January 8, 2024

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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 2025 (CMS-9895-P)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) and the Habilitation Benefits (HAB) Coalition appreciate the opportunity to jointly comment on the *HHS Notice of Benefit Payment Parameters for 2025* proposed rule ("Proposed Rule").

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. 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 existing federal law.[1]

The Proposed Rule sets forth benefit and payment parameters, provisions related to EHBs, qualified health plans (QHPs), risk adjustment, and the operation of Federally-facilitated exchanges (FFEs) and State-based exchanges (SBEs), as well as many other policies implementing the Affordable Care Act (ACA). This comment letter will focus on key proposed provisions that relate to enrollees in need of medical rehabilitation and post-acute care, specifically rules related to the essential health benefit category of "rehabilitation and habilitation services and devices," provider network adequacy requirements, and the sufficiency of current coverage and limits for rehabilitative and habilitative services.

[1] Patent Protection and Affordable Care Act ("ACA"), Section 1302.

I. The Importance of Rehabilitative and Habilitative Services and Devices

Rehabilitation services are provided to help a person regain, maintain, or prevent deterioration of a skill, condition, or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition. Rehabilitation services are essential to enable people with injuries, illnesses, and disabilities to:

- Improve, maintain, or slow deterioration of health status;
- Improve, maintain, or slow deterioration of functional abilities;
- Live as independently as possible;
- Return to work, family, and community activities as much as possible;
- Avoid unnecessary and expensive re-hospitalization and nursing home placement; and
- Prevent secondary medical conditions.

Rehabilitation services are closely related to habilitation services, which focus on skills, conditions, and functions that were never acquired. Rehabilitative and habilitative services and devices include but are not limited to rehabilitation medicine, inpatient rehabilitation hospital care, physical and occupational therapy, speech language pathology services, behavioral health services, recreational therapy, developmental pediatrics, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings.

There is a compelling case for coverage of both rehabilitative and habilitative services and devices for persons in need of functional improvement due to disabling conditions. These services and devices are designed to maximize the functional capacity of the individual, which has profound implications on the ability to perform activities of daily living in the most independent manner possible. Both rehabilitative and habilitative services and devices are highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

Defining Habilitative and Rehabilitative Services

In the February 2015 Notice of Benefits and Payment Parameters Final Rule, the Centers for Medicare and Medicaid Services (CMS) defined "habilitation services and devices" using the definition of "habilitation services" from the National Association of Insurance Commissioners' Glossary of Health Coverage and Medical Terms and explicitly added habilitation devices, as follows:

> *"Habilitation 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. However, prior to passage of the Affordable Care Act, habilitation benefits were largely viewed

as a Medicaid benefit and, hence, the scope and content of the habilitation benefits package was not well understood. The CPR and HAB Coalition believes this lack of familiarity with habilitation benefits has limited its adoption as a mainstream private insurance benefit under the ACA.

Nonetheless, the CPR and HAB Coalition supports the preservation of the regulatory definition of habilitative services and devices and related interpretations that have been duly promulgated and believe that this should be the *baseline* for all states in their implementation of essential health benefits (EHB). We encourage CMS to work with the states to enhance implementation and enforcement of habilitation coverage. Additionally, we urge CMS to reemphasize the following requirements and principles to the States with regard to EHB benchmark plan design:

- The uniform definition of habilitative services and devices serves as a minimum standard for covering habilitative services.
- The ACA statutory language requires the EHB package to include coverage of both habilitation services *and* devices.
- Limitations in habilitation benefits of any kind should be based on the best available evidence and such decisions should be made by professionals with sufficient knowledge and expertise in the habilitative field to render informed decisions.
- The extent of coverage of habilitative services and devices should reflect the patient population that requires these benefits. Any caps or limitations should be evidence based and reflect medically necessary care.
- Regardless of the diagnosis that leads to a functional deficit in an individual, the coverage and medical necessity determination for rehabilitative and habilitative services and devices should be based on clinical judgments of the effectiveness of the therapy, service, or device to address the deficit.
- Benefits cannot be defined in such a way as to exclude coverage for services based upon age, disability, or expected length of life—an explicit requirement included in the ACA.

To provide further clarity between what services and devices habilitation covers versus what rehabilitation covers, we also ask CMS to provide a definition in regulation of "rehabilitation services and devices." We view as an oversight the fact that CMS codified a habilitation benefit definition in regulation but did not do so for rehabilitation services and devices. This inconsistent regulatory treatment makes it more difficult to effectuate either benefit. While many services and devices between habilitation and rehabilitation are similar, there is a clear difference in the reason each service is being provided. To ensure accurate implementation of both habilitation and rehabilitation coverage, we believe there must be a regulatory definition for both. Therefore, the CPR and HAB Coalition recommends that CMS include the following definition, as is outlined in the in the Glossary of Health Coverage and Medical Terms, into regulation in its ACA regulations:

> *"Rehabilitative services and devices – Health care services that help a person keep, get back, or improve skills and functioning for daily living that have 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."*

II. Essential Health Benefits Benchmark Update Process Improvements

Under current policy, the cost of state benefit mandates (SBMs) that apply to Marketplace plans enacted after December 31, 2011, that are in addition to EHBs, must be borne by the states. Simultaneously, states can select a new or revised EHB-benchmark plan without facing an obligation to defray the cost of additional benefits so long as the plan meets certain standards. In the Proposed Rule, CMS is proposing adjustments to the EHB defrayal policy and the standards governing updates to the EHB-benchmark plan.

The current "defrayal" policy is complex, as well as difficult to understand and operationalize. As such, CMS is proposing to amend its rules to reflect that a covered benefit in the state's EHB-benchmark plan is considered an EHB. In other words, if a state mandates coverage of a benefit that is already in the EHB-benchmark plan, the benefit would continue to be considered an EHB, and therefore, there would be no defrayal requirement. CMS notes that there are some states currently defraying the cost of certain benefits that would no longer be necessary if the rule is finalized.

Additionally, CMS is also proposing to change the standards by which states select a new or updated EHB-benchmark plan, beginning on or after January 1, 2027. Currently, states are required to meet two scope-of-benefit standards:

1. The typicality standard: The proposed EHB-benchmark plan must have a scope of benefits that equals those in a typical employer plan. A "typical" employer plan could either be one of the state's 10 base-benchmark plan options from the 2017 plan year, or the largest health insurance plan by enrollment within one of the five largest large group health insurance products.
2. The generosity standard: The proposed EHB-benchmark plan must have a scope of benefits that is not more generous than the most generous plan among a set of comparison plans used for the 2017 plan year.

CMS is proposing to remove the generosity standard and streamline the typicality standard so that a state's proposed EHB-benchmark would need to have a scope of benefits that is:

1. As or more generous than the scope of benefits in the state's least generous typical employer plan (aka, the floor).
2. As or less generous than the scope of benefits in the state's most generous typical employer plan (aka, the ceiling).

Under this proposal, states would therefore only need to assess two typical employer plan options (the most and least generous available). **The CPR and HAB Coalitions support these updates to the EHB benchmark process as we believe that these proposals should increase access to essential health benefits and reduce the time and cost to states seeking to update their EHB-benchmark plans.**

Inclusion of Adult Dental Services in EHBs

Under current regulations, Marketplace insurers are prohibited from including routine adult dental services as an EHB, even if a state's EHB-benchmark plan includes those services as covered benefits. CMS is proposing to remove that regulatory prohibition in this Proposed Rule, noting research which suggests that routine non-pediatric dental services are commonly covered as an employer-sponsored benefit. States would also be permitted to include routine adult dental services as an EHB for purposes of their Medicaid Alternative Benefit or Basic Health Program health plans, which we support.

Dental coverage and access to dental services are essential to good oral health. Poor oral health is linked to respiratory, cardiovascular, and other avoidable diseases in the adult population, in particular. **The CPR and HAB Coalitions fully support this proposal, under which states seeking to improve access to oral healthcare could update their EHB-benchmark plans to include coverage of routine adult dental services.** Allowing issuers to include routine non-pediatric dental services as an EHB is a common-sense proposal that would ensure adults with disabilities are able to access and receive the dental care they need and deserve.

III. Network Adequacy

The adequacy of a plan's provider network can impact the level of access to benefits for enrollees. Health plans participating in the Federally Facilitated Marketplace (FFM) must comply with federal standards for network adequacy that set a cap on the time or distance enrollees must travel to obtain provider services. This Proposed Rule would require State-Based Marketplaces (SBMs) and State-Based Marketplaces using the federal platform (SBM-FP) to establish their own time and distance standards that are "at least as stringent" as those required of plans in the FFM. In addition, SBMs and SBM-FPs would also be required to conduct reviews of plan networks to ensure they meet those standards before those plans can be certified to participate. However, SBMs and SBM-FPs could permit insurers who cannot meet those standards to submit justifications, such as explanations or workforce shortages or geographical challenges, in order to be certified.

CMS notes in the Proposed Rule that many Marketplace plans now come with narrow provider networks, resulting in potential access challenges for enrollees. CMS has further observed that approximately twenty-five percent of SBMs and SBM-FPs do not have quantitative standards for network adequacy of Marketplace plans. SBMs and SBM-FPs that have their own quantitative network adequacy standards that differ from FFM's standards, would be allowed to seek exceptions to such requirements to maintain time and distance standards as stringent as the federal ones. Such states must be able to show that their standards ensure reasonable access to services for plan enrollees, and that they conduct compliance reviews prior to plan certification. SBMs or SBM-FPs that fail to comply with the new expectations for network adequacy oversight could be subject to remedial action by CMS under its program integrity authority.

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—no matter the QHP in which they are enrolled. **We believe 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. Additionally, network adequacy standards should ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under a plan. In light of these concerns, review processes must ensure robust network adequacy standards and these standards must be strongly enforced. It is essential that Americans have access to affordable and meaningful coverage of rehabilitative services and devices through the private insurance market.

IV. Sufficiency of Current Coverage and Limits for Rehabilitation and Habilitative Services – Separating and Limiting Rehabilitation and Habilitation Caps

In January 2023, we enthusiastically responded to CMS's Request for Information (RFI) on EHBs. Our comments focused on ways to improve the rehabilitative and habilitative benefits by separating and limiting the therapy caps associated with both benefits. In our comments from January, and as illustrated again below, we recommended that CMS adopt the approach Medicare used to address the outpatient therapy caps under that program. That Medicare policy was finalized in 2017 to create a therapy cap exceptions process so patients can get access to the rehabilitation services they need throughout their lifetime (habilitation is not covered by the Medicare program). While we were hopeful CMS would have addressed some of these concerns mentioned in response to the EHB RFI in this Proposed Rule, we encourage the Agency to move forward with addressing the RFI, and our recommendations, as expeditiously as possible.

Since the Balanced Budget Act of 1997, CMS imposed Medicare caps on outpatient physical therapy, occupational therapy, and speech-language pathology services by all providers, other than hospital outpatient departments. The law required a combined cap for physical therapy and speech-language pathology, and a separate cap for occupational therapy. An exceptions process was eventually established to ensure Medicare beneficiaries received rehabilitation services deemed medically necessary, even if the amount of those therapy services exceeded the cap. **CMS should move forward with a requirement on all ACA plans that if such plans employ the use of visit limits in outpatient rehabilitation or habilitation therapy services, the plans must adopt an exceptions process similar to the process established under the Medicare program to ensure that ACA plan enrollees can get access to critical therapy services when they are determined to continue to be medically necessary.**

The CPR and HAB Coalition strongly encourages that if service caps in benefits continue to be permitted under ACA plans, there must continue to be separate caps for rehabilitation and habilitation benefits. Beginning in 2017, CMS interpreted the ACA as mandating that all individual and small-group, non-grandfathered health plans utilizing visit limits must establish separate limits for habilitative and rehabilitative services, where clinicians need to identify whether a provided service is habilitative or rehabilitative for purposes of the caps. However, simply importing the limits and exclusions that may exist under a plan's rehabilitation benefit and applying those same limits and exclusions to the habilitation benefit seriously undermines the ACA plan enrollees' access to both rehabilitation and habilitation services and devices.

Rehabilitation therapy caps were created with the typical orthopedic adult in mind. For instance, a joint replacement or other common orthopedic procedure typically requires outpatient therapy of moderate duration, intensity, and scope. However, habilitation benefits are more typically provided to young children who may have serious delays in achieving certain functional milestones that must be achieved before progressing to the next set of skills in preparation for adolescence and adulthood. A three-year-old with developmental disabilities and functional deficits has fundamentally different needs from a 60-year-old tennis player who needs a knee replacement. Any ACA plans that employ the use of rehabilitation and habilitation caps in benefits must recognize these differences and tailor their limits accordingly, in a manner that ensures access to medically necessary care. No ACA beneficiary with habilitation needs should be denied services or devices based on the typical needs of orthopedic rehabilitation patients.

As an example of the significant differences between rehabilitation and habilitation benefits, particularly among young individuals who may need therapy services at numerous points in a given year, consider a baby born with Prader-Willi syndrome that requires physical therapy (PT) for muscle weakness, speech-language therapy (SLT) for feeding and swallowing difficulties, and occupational therapy (OT) for fine motor skill development and sensory integration. If benefit caps or limits are permitted in this instance, they should be imposed separately for habilitation services and habilitation devices and any cap or limitation should start anew with each specific reason for habilitation therapy intervention. As this example demonstrates, a habilitation benefit limitation based on a rehabilitation benefit for acute illness or injury will often be seriously insufficient to support this child as they grow, develop, acquire new skills, and achieve new and more advanced functional milestones. The habilitation benefit should be designed with the intent to recognize and allow for frequent and lifelong therapeutic visits.

Furthermore, the CPR and HAB Coalition also recommend that, if ACA plans employ the use of benefit caps or limits, the plans are required to use separate visit caps for PT, OT, and SLP. This would ensure that patients with multiple co-occurring or unrelated conditions will be able to access sufficient therapy. For example, a child born with Down Syndrome may need help through physical therapy to gain core strength due to atlantoaxial instability and speech language therapy to help improve their communication skills. If combined under one benefit cap for the entire year, that same child will quickly meet his or her benefit limit. Therefore, there should be clear and separate caps that are applied for each type of therapy per condition.

Rehabilitation and Habilitation Caps Modifiers

In an effort to clearly differentiate habilitative and rehabilitative visits and services, the CPR and HAB Coalition encourages the use of the separate habilitation and rehabilitation modifiers as were added in Appendix A of the 2018 Current Procedural Terminology (CPT) code book.

In 2017, the most common method for tracking habilitative services was through the -SZ modifier, which is added to the corresponding 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 was 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 that can be added to the appropriate CPT codes on claims submitted to ACA-compliant and other health insurance plans include the following:

- **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 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. **The CPR and HAB Coalition recommends that CMS consider additional policies to encourage the use of these CPT modifiers for habilitative and rehabilitation services (96 and 97, respectively) by all qualified health plans (QHPs) participating in the Exchanges.** Moreover, CMS should also 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 and devices.

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We greatly appreciate your consideration of our comments on the *HHS Notice of Benefit Payment Parameters for 2025* proposed rule. Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the CPR and HAB Coalitions

ACCSES*
ADVION
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability

American Cochlear Implant Alliance
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association*
American Speech-Language-Hearing Association*
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
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National Association of Rehabilitation Providers and Agencies
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National Athletic Trainers' Association
RESNA
Spina Bifida Association
United Spinal Association*

****Member of the CPR or HAB Coalition Steering Committee***