November 12, 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 2026 (CMS-9888-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 2026* proposed rule ("Proposed Rule"), which was published in the Federal Register on October 4, 2024.

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," 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 Coalitions believe 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 Coalitions support 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 Coalitions recommend that CMS include the following definition, as is outlined 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. Sufficiency of Current Coverage and Limits for Rehabilitative and Habilitative Services and Devices

The CPR and HAB Coalitions have approached the Center for Consumer Information and Insurance Oversight ("CCIIO") before on multiple occasions both in-person and virtually to discuss ways to improve the rehabilitative and habilitative benefits by separating and limiting the impact of the therapy caps associated with both benefits. Both Coalitions have also submitted extensive written comments on this specific topic in response to previous annual Notice of Benefit and Payment Parameters proposed rules. Furthermore, both Coalitions also jointly responded to CMS' Request for Information ("RFI") on EHBs in January 2023 stressing similar points.

As recently as September 2024, both Coalitions met with senior officials at CCIIO to discuss solutions to overcome the impact of therapy caps in state-regulated ACA plans and we left that meeting feeling hopeful that CMS would address some of our concerns mentioned during the meeting, or in response to the EHB RFI, in this Proposed Rule. However, we are disappointed that, once again, neither CMS nor CCIIO have addressed this issue in any written regulatory activity. Given this trend, we will continue to reiterate our concerns below in hopes of generating adoption of our position at CMS as soon as practicable.

Restatement of the Problem

The ACA prohibits annual and lifetime dollar limits on EHBs, but it does not explicitly prohibit caps on the number of visits or services a person can receive. Insurers can still impose visit limits on certain types of care, such as outpatient "rehabilitative and habilitative services and devices," one of the EHB categories explicitly listed in the statute. Visit limits can vary depending on the type of service and how insurers define EHBs within the framework of the ACA. Typically, it is common to see ACA plans limit rehabilitative and habilitative services and devices to an arbitrary number of visits per episode, per year (e.g., 20 visits).

Caps and limitations in therapy benefits are not—and have never been—evidence-based. They are imposed by health plans to save money, plain and simple, regardless of medical necessity. Therapy caps as restrictive as 20 visits per episode of care are largely based on the typical orthopedic patient who may find this narrow scope of therapy benefit sufficient. But individuals with any significant injury, illness, disability or chronic condition, such as brain injury, spinal cord injury, multiple trauma, neurological conditions, and other significant disabilities find these therapy caps completely inadequate to meet their medically necessary needs. These caps are nearly universal in private insurance and systematically underserve ACA plan enrollees, requiring individuals in need to endure an exhausting appeals process, pay out of pocket, or go without—resigning themselves to accept a less functional life and lifestyle for themselves and their loved ones.

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. These caps only actually went into effect for a short period of time as Congress routinely waived the caps annually and offset the costs of these waivers through legislation. 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. To date, while the Medicare outpatient therapy benefit is not perfect, by most accounts, the exceptions process has proven an effective remedy to ensuring that Medicare beneficiaries receive appropriate access to medically necessary outpatient therapy services.

Restated Recommendations

Our preferred regulatory approach is for CMS to interpret the nondiscrimination provisions of the ACA to prohibit therapy caps in ACA plans across the board. As an alternative, however, CMS and CCIIO 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 and devices, 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 by their treating practitioner to continue to be medically necessary.

In addition, the CPR and HAB Coalitions strongly encourage CMS 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.

As already stated, 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 than a 65-year-old tennis player who requires a knee replacement. All ACA plans that employ the use of rehabilitation and habilitation caps in benefits must recognize these differences and should tailor their limits accordingly (e.g., through an exceptions process), 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 for muscle weakness, speech-language therapy for feeding and swallowing difficulties, and occupational therapy 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 or condition 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 ongoing therapeutic visits.**

Furthermore, the CPR and HAB Coalitions also recommend that, if ACA plans employ the use of benefit caps or limits, the plans should be 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 exceed his or her benefit limit. Therefore, there should be clear and separate caps that are applied for each type of therapy per condition per benefit period, along with an exceptions process to ensure appropriate access to medically necessary care.

During our most recent meeting with CCIIO, we recommended that CMS eliminate the arbitrary caps on rehabilitative and habilitative services and device and adopt the approach Medicare uses 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.

Potential Section 504 and 1557 Concerns

The CPR and HAB Coalitions believe arbitrary therapy caps of all types disproportionately discriminate against individuals with disabilities. The therapy caps imposed under the ACA raise serious concerns under Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the ACA, both of which have recently been regulated. Section 504 prohibits discrimination in medical treatment decisions by health programs or activities that receive federal financial assistance. Section 1557 prohibits discrimination based on race, color, national origin, sex, age, or *disability* in health programs or activities that receive federal financial assistance. The regulation further states that, "this includes the designing of benefits in a manner that discriminates based on an individual's expected length of life, present or predicted

disability, degree of medical dependency, or other health conditions."[2] We believe that where there is a hard cap for rehabilitative and habilitative services and devices and not in other benefit categories (such as office visits and surgical services), such caps are discriminatory based on disability and the health status of the individual to which they are being imposed, which is prohibited by the ACA.

It is important to note that CPR and HAB Coalition members rarely hear from enrollees who have minor or modest rehabilitation therapy needs as the therapy caps do not typically prevent medically necessary care from being delivered to these patients. It is the enrollees with extensive needs who routinely exceed the therapy caps and visit limits, resulting in negative outcomes and creating unnecessary disability, lack of function, and ultimately, increased long term costs. Given the enormous impact that these therapy caps have on the enrollees who need the most extensive care, we urge CCIIO to increase its enforcement and compliance to ensure nondiscrimination in benefit design for EHBs. This increased enforcement and compliance would pressure-test some of these plans to make sure they are meeting patient needs, especially in light of the pervasive lack of clinical evidence for therapy caps.

Rehabilitation and Habilitation Caps Modifiers

If our preferred regulatory approach to repeal therapy caps in ACA plans across the board is not an option, the CPR and HAB Coalitions encourage the use of the separate habilitation and rehabilitation modifiers as were added in Appendix A of the 2018 Current Procedural Terminology (CPT) code book to clearly differentiate habilitative and rehabilitative visits and services.

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."

[2] 45 C.F.R. § 92.207

- **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 Coalitions recommend 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 2026 Proposed Rule.* Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR and the HAB Coalitions, 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*
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*
Association of Academic Physiatrists
Brain Injury Association of America*
Center for Medicare Advocacy*
Chanda Center for Health
Children's Hospital Association*
Epilepsy Foundation of America
Falling Forward Foundation*
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics

National Association of Councils on Developmental Disabilities
National Association of Rehabilitation Providers and Agencies
National Association of Social Workers (NASW)
National Athletic Trainers' Association
National Disability Rights Network (NDRN)
RESNA
Spina Bifida Association
United Cerebral Palsy
United Spinal Association*

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