ASHA
American
Speech-Language-Hearing
Association

Submitted via https://www.regulations.gov/

January 27, 2023

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

RE: Request for Information; Essential Health Benefits

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on Essential Health Benefits.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 223,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA and CMS share a goal to improve health care coverage. As a member association that represents those providing both habilitative and rehabilitative services and devices, we appreciate the opportunity to provide feedback on essential health benefits, particularly the habilitation benefits category.

The RFI states:

> "Many State base-benchmark plan documents do not include specific coverage for habilitative services. To comply with section 1302(b)(1)(G) of the Affordable Care Act (ACA), these States supplement the base-benchmark plans with habilitative services pursuant to § 156.110(f) by determining which services in that category will be covered as EHB. In our experience, State supplementation of habilitative services is inconsistent. **We are interested in comments on which habilitative services are currently covered as EHB, and whether further definition is needed in general to clarify the covered benefits. We also seek comment on whether EHB-benchmark plans' current coverage and limits regarding habilitative services, which were primarily based on coverage for rehabilitative purposes, are sufficient and in line with current clinical guidelines for treatment of developmental disabilities**."

ASHA appreciates CMS highlighting the coverage of habilitation services and devices across ACA health plans and the inconsistency of state supplementation of these benefits. ASHA recommends standardizing the definition of habilitation services by adopting the definition from the National Association of Insurance Commissioners' Glossary of Health Coverage and Medical Terms found below. We also appreciate the recognition that habilitation benefit limits were based on rehabilitation benefit limits that were designed for a very different patient population. ASHA recommends that medical necessity and best-available evidence should

determine the frequency and duration of therapy services, rather than setting therapy limits. We have directed the majority of our comments at answering this habilitative benefits question.

Differences Between Habilitative and Rehabilitative Services and Devices

Habilitative services and devices are provided to help a person *attain*, maintain, or prevent deterioration of a skill or function **never learned or acquired** for daily living. In contrast, *rehabilitative* services and devices help a person *regain*, maintain, or improve skills and functioning for daily living **that have been lost** or impaired due to illness, injury, or disabling condition.

Following are examples of the differences between habilitation services and rehabilitation services.

- A speech-language pathologist providing speech therapy to a 3-year-old with autism who has never acquired the ability to speak would be considered *habilitation* but providing speech therapy to a 3-year-old to regain speech after a traumatic brain injury would be considered *rehabilitation*.

- A child born with severe to profound hearing loss who is fit with hearing aids receives audiologic *habilitation* to develop speech and language skills; however, an adult with sudden onset hearing loss and tinnitus who is fit with hearing aids receives audiologic *rehabilitation* to improve listening skills and to cope with tinnitus.

The services and devices used in habilitation are often the same or similar as in rehabilitation, as are the professionals who provide the services, the settings in which the services and devices are provided, the individuals receiving the services, the functional deficits being addressed, and the improvement in functional outcomes that result from treatment. The only meaningful difference is the reason for the service; that is, whether a person needs to *attain* a function from the outset or *regain* a function lost to illness or injury. There is a compelling case for coverage of both habilitation and rehabilitation services and devices in persons in need of functional improvement due to disabling conditions, and the ACA's essential health benefits package reflects this need. From an economic standpoint, both habilitation and rehabilitation services and devices are highly cost-effective and decrease downstream costs to the health care system due to unnecessary disability and dependency.

The following examples demonstrate real-life instances where access to habilitation services and devices has maximized the health, function, and independence of those who have been able to access these services.

- *Cleft Palate.* Jessica is a 2-year-old child with a bilateral cleft palate that was surgically repaired at 11 months of age. Jessica presented with speech sound production errors and excessive nasality that impaired her ability to be understood when communicating. Jessica's care is coordinated by a cleft palate/craniofacial team that includes a plastic surgeon, an orthodontist, an SLP, a pediatrician, and additional providers. With appropriate speech-language pathology treatment, Jessica will learn techniques to improve her speech intelligibility, allowing her to communicate with others at an age-appropriate level. Professional collaboration with the craniofacial team and a coordinated care plan ensure that Jessica achieves maximum functional communication.

- *Cochlear Implants.* Raul was diagnosed with congenital hearing loss as a young child but did not have access to hearing aids until age 10. Raul attended a school for the deaf and hard of hearing, and his primary language is American Sign Language. As an adult, Raul decided to undergo cochlear implant surgery and learn spoken language. Raul works with an audiologist and SLP on open-set speech recognition with amplification. The prognosis from the interdisciplinary cochlear implant team—based on Raul's motivation, progress in therapy, and use of lip-reading and technology—is fair for receptive language abilities. Raul's cochlear implant and related new skills help support communication in the workplace and community.

Habilitative Services and Rehabilitative Service Definitions

In the February 2015 Notice of Benefits and Payment Parameters Final Rule, CMS defined "habilitation services and devices" using the definition 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.

ASHA supports the preservation of the regulatory definition of habilitative services and devices and believe that this should be the *baseline* for all states in their implementation of essential health benefits (EHBs). ASHA would support efforts for CMS to work with states on enhancing the implementation and enforcement of habilitation coverage, such as annual audits for 25% of the states by similar specialty reviewers. Additionally, we urge CMS to reemphasize the following requirements and principles to the states regarding 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 their 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 habilitative and rehabilitative services and devices should be based on providers' 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 compared to what rehabilitation covers, ASHA requests that CMS provide a definition in regulation for "rehabilitation services and devices." ASHA acknowledges that it was an unintended oversight by CMS who codified a habilitation benefit definition in regulation but did not do so for rehabilitation services and devices. This inconsistent regulatory treatment makes it 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, ASHA recommends that CMS include the following definition, as is outlined in the in the Glossary of Health Coverage and Medical Terms, 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."*

Current Coverage and Limits for Habilitative Services—Separating and Limiting Habilitation and Rehabilitation Caps

The Balanced Budget Act of 1997 required CMS to impose an annual financial limitation, commonly known as the 'therapy cap', 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 services, and a separate cap for occupational therapy. An exceptions process was eventually established to ensure Medicare beneficiaries received rehabilitation services deemed medically necessary. In 2018, Congress permanently repealed the therapy cap and replaced it with an administrative claims submission process to preserve the integrity of therapy billing. The repeal was a recognition on the part of Congress that "hard" caps on health care services and devices failed to consider the individual clinical needs of Medicare beneficiaries. In 2017, CMS began interpreting 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 the purpose of setting caps on services.

If service caps in benefits continue to be permitted, ASHA strongly encourages separate caps for habilitation and rehabilitation benefits that recognize the clinical distinctions between patients needing habilitative services and devices and patients needing rehabilitative services and devices. Importing the limits and exclusions that may exist under a plan's habilitation benefit and applying those same limits and exclusions to the rehabilitation benefit seriously undermines the ACA's habilitation mandate. Habilitation benefits are defined as services that help individuals *attain* functions and skills that they have never learned or acquired for daily living. This may entail major variations in the amount, duration, and scope of needed services compared to the typical rehabilitation patient. ASHA recommends that any

caps be based on best available evidence as outlined above. If the limits are the same across habilitation and rehabilitation, then an evidence-based justification should be included.

Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit uses the standard of medically necessary services with a prohibition on hard caps. This model, used with children under age 21 who are enrolled in Medicaid, is more aligned with the typical habilitation population than the therapy cap model built on an acute rehabilitation benefit.

It is unclear if Medicare's rehabilitation therapy caps were created based on clinical considerations or in an effort to constrain spending. Financial considerations should be secondary to the needs of patients and the clinical judgment of the patient's health care providers. It is possible the caps were developed, in part, with the typical adult orthopedic rehabilitation in mind. For instance, a joint replacement or other common orthopedic procedure typically requires outpatient therapy of modest duration, intensity, and scope. However, habilitation benefits are 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 3-year-old with developmental disabilities and functional deficits has fundamentally different needs than a 60-year-old tennis player who needs a knee replacement. **Any ACA plan that employs the use of habilitation and rehabilitation caps on 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 rehabilitation patients, such as the orthopedic rehabilitation example above.

To further clarify the significant differences between habilitation and rehabilitation benefits—particularly among young individuals who may need to multiple therapy services—consider a baby born with Prader-Willi syndrome who requires physical therapy (PT) for muscle weakness, occupational therapy (OT) for fine motor skill development and sensory integration, and speech-language pathology services for feeding and swallowing difficulties. **If benefit caps/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 and they grow, develop, acquire new skills, and achieve new and more advanced functional milestones. Therefore, **ASHA recommends that the habilitation benefit be designed to recognize and allow for frequent and lifelong therapeutic visits.**

ASHA also recommends that if ACA plans employ the use of benefit caps/limits, then the plans should be required to use separate visit caps for each type of service provided; therefore, there would be different caps for PT, OT, and speech-language pathology services. 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 PT to gain core strength due to atlantoaxial instability and speech-language pathology services to help improve their communication skills. If combined under one benefit cap for the entire year, that same child will quickly meet their benefit limit. Therefore, there should be separate caps that are applied for each type of therapy per condition.

Current Coverage and Limits for Habilitative Services—Habilitation and Rehabilitation Caps Modifiers

In an effort to clearly differentiate habilitative and rehabilitative visits and services, ASHA encourages the use of the modifiers 96 (habilitative services) and 97 (rehabilitative services) that were added in Appendix A of the 2018 Current Procedural Terminology (CPT) code book to distinguish between the two types of 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; thereby, 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 and/or misclassification, 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."

While CMS has taken important steps to implement a federal standard, more education is needed to engage applicable payers and ensure compliance. A 2022 report, conducted on behalf of ASHA and the American Occupational Therapy Association (AOTA), analyzed annual utilization of select audiology, occupational, and speech-language pathology codes and modifiers. The report indicated that only 0.2% (96) and 0.1% (97) of speech-language pathology codes analyzed in the individual and small group markets—where separate visit limits for habilitative and rehabilitative services are required—actually used modifiers to make the distinction. Use of the modifiers was similar in other lines of business (i.e., large group, Medicare fee-for-services, Medicare Advantage, Medicaid managed care) where separate visit limits are not required. For these reasons, **ASHA requests that CMS engage in an educational campaign** with relevant payers and providers to assure there is a pathway for therapy professionals to indicate these types of services on their claims when appropriate. In addition, **ASHA recommends that CMS collect and make publicly available data on the services provided in these benefits identified by the modifiers**. This data will help determine the availability of these services and any potential barriers to access or imbalances between coverage of habilitation and rehabilitation services and devices.

Proposed Revisions to 45 CFR Part 156.115 Provision of EHB

ASHA recommends that CMS make the following modifications (as underlined) to 45 CFR Part 156.115 to capture the definition and visit limit issues discussed above, which further supports the standardization, coverage, and compliance with ACA EHB requirements.

(a) Provision of EHB means that a health plan provides benefits that -

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of § 156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under § 156.110(a)(5), comply with the requirements under section 2726 of the Public Health Service Act and its implementing regulations.

(4) Include preventive health services described in § 147.130 of this subchapter.

(5) With respect to habilitative and rehabilitative services and devices -

(i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). 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;

(ii) Cover health care services and devices 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 (rehabilitative services). These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings;

(iii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices;

(iv) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices;

(v) Provide separate limits per condition per benefit period;

(vi) Provide separate limits for occupational therapy, physical therapy, and speech-language pathology services; and

(vii) Provide an exceptions process to obtain medically necessary services that exceed quantitative limits.

(6) For plan years beginning on or after January 1, 2016, for pediatric services that are required under §156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.

(b) An issuer of a plan offering EHB may substitute benefits for those provided in the EHB-benchmark plan under the following conditions -

(1) The issuer substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(4) of this section; and

(ii) Is not a prescription drug benefit.

(2) An issuer may substitute a benefit within the same EHB category, unless prohibited by applicable State requirements. Substitution of benefits between EHB categories is not permitted.

(3) The plan that includes substituted benefits must:

(i) Continue to comply with the requirements of paragraph (a) of this section, including by providing benefits that are substantially equal to the EHB-benchmark plan;

(ii) Provide an appropriate balance among the EHB categories such that benefits are not unduly weighted toward any category; and

(iii) Provide benefits for diverse segments of the population.

(4) The issuer submits to the State evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined without taking cost-sharing into account.

(c) A health plan does not fail to provide EHB solely because it does not offer the services described in § 156.280(d) of this subchapter.

(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

ASHA appreciates the opportunity to provide comments in response to the RFI. If you or your staff have any questions, please contact Rebecca Bowen, MA, CCC-SLP, ASHA's director for health care policy, value, and innovation, at rbowen@asha.org.

Sincerely,

Robert M. Augustine, PhD, CCC-SLP
2023 ASHA President