January 31, 2023

VIA ELECTRONIC SUBMISSION

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

RE: Request for Information; Essential Health Benefits

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) Request for Information (RFI); Essential Health Benefits. As a coalition dedicated to raising awareness and promoting coverage of habilitative services and devices, we appreciate the opportunity to provide feedback on essential health benefits, and particularly the habilitation benefits category.

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 decade to assist with implementation of the ACA's prohibition against discrimination based on health status in the individual and small group health insurance markets, which disproportionately impacts people with disabilities and chronic conditions. Expanding access to habilitation services and devices has been a major focus of our efforts.

The HAB coalition particularly appreciated the question in the RFI on essential benefits regarding ways to improve the habilitative benefit, and the effort to understand if the current definition and coverage of habilitation is sufficient. Specifically, 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 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**.

We applaud CMS for highlighting the adequacy of coverage of habilitation services and devices across ACA health plans and the inconsistency of state supplementation of these benefits. We also appreciate the recognition that habilitation benefit limits were adopted from rehabilitation benefit limits that were designed for a very different patient population. We have directed the majority of our comments at answering this habilitative benefits question.

Background on Habilitative Services:

Rehabilitative services help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because of illness, injury, or disability. In contrast, *habilitative* services and devices help a person keep, learn, or improve skills and functioning for daily living. In other words, an important difference between rehabilitation and habilitation services and devices is the fact that *habilitation* services are provided to assist a person to *attain*, maintain or prevent deterioration of a skill or function never learned or acquired. *Rehabilitation* services and 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.

Examples of the comparison between rehabilitation (where the individual *regains*, maintains, or prevents deterioration of a function or skill) and habilitation (where the individual *attains*, maintains, or prevents deterioration of a function or skill) are as follows:

- 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 fit with hearing aids receives audiologic habilitation to develop speech and language skills; an adult with hearing loss and tinnitus fit with hearing aids equipped with sound generators receives audiologic rehabilitation to improve listening skills and to cope with tinnitus.

- An occupational therapist teaching children who have had a stroke *in utero* or children or adults with developmental disabilities the fine motor coordination required to groom and dress themselves is considered habilitation, whereas teaching children or adults who have had a stroke the fine motor skills required to re-learn how to groom and dress themselves would be rehabilitation.

- An orthotist or therapist fitting hand orthoses for a child or an adult with a congenital condition to correct hand deformities would be habilitation, while fitting orthoses for a child or adult who has had hand surgery for a torn tendon repair would be rehabilitation.

- A physical therapist who teaches a child how to improve a congenital walking abnormality would be providing habilitation, while a physical therapist who teaches a child to regain the ability to walk following a car accident would be providing rehabilitation.

The services and devices used in habilitation are often the same or similar as in rehabilitation, as are the professionals who provide these 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 need for the service; 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 rehabilitation and habilitation 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 for unnecessary disability and dependency.

The following vignettes demonstrate just a few examples of 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. She presented with speech sound production errors and excessive nasality that impaired her ability to communicate. Jessica's care is coordinated by a cleft palate/craniofacial team that includes a plastic surgeon, an orthodontist, a speech-language pathologist (SLP), a pediatrician, and additional providers. With appropriate speech language 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.

- *Muscular Dystrophy.* Adam is a 14-year-old boy with Duchenne Muscular Dystrophy. He has recently experienced a significant decrease in his trunk and arm strength. After conducting an occupational profile and evaluating Adam's current performance skills, the occupational therapist adapted Adam's computer keyboard to enable him to continue to

use the computer and keyboard for schoolwork and entertainment. She teaches Adam compensatory strategies and modifies his silverware so he may continue to feed himself without assistance, and teaches him and his family strategies for dressing with minimal assistance from his caregivers. The occupational therapist also teaches Adam stretching exercises for his shoulders and upper arms to help maintain flexibility and prevent the development of muscle contractures. Finally, she teaches Adam new strategies for relieving pressure on his buttocks in his wheelchair, as he can no longer perform wheelchair "pushups." She works with Adam to build these techniques into his daily routine so he does not forget, since forgetting could result in the development of additional pressure sores.

- *Cochlear Implants.* Raul was diagnosed with congenital hearing loss as a young child but did not have access to hearing aids until age ten. He 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. He 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. His cochlear implant and related new skills will assist him with communication in the workplace and community.

Defining Habilitative Services 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 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 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 that 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 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."*

Sufficiency of Current Coverage and Limits for Habilitative Services -- Separating and Limiting Rehabilitation and Habilitation Caps:

Since the Balanced Budget Act of 1997, CMS has 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. Starting 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.

The HAB coalition strongly encourages that if service caps in benefits continue to be permitted, there must continue to be separate caps for habilitation and rehabilitation benefits. 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's habilitation mandate. Habilitation benefits are defined as services that help individuals attain functions and skills they have never attained due to illness or injury. . This may entail major variations in amount, duration, and scope of needed services in comparison to the typical rehabilitation patient.

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 modest 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 the rehabilitation and habilitation benefit, particularly among young individuals who may need to experience 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 and 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.

Further, the HAB Coalition also recommends 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 separate caps that are applied for each type of therapy per condition.

Sufficiency of Current Coverage and Limits for Habilitative Services -- Habilitation and Rehabilitation Caps Modifiers:

In an effort to clearly differentiate habilitative and rehabilitative visits and services, we also encourage the use of the separate habilitation and rehabilitation modifiers as were added in Appendix A of the 2018 CPT code book.

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 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 HAB Coalition recommends that CMS consider additional policies to encourage the 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 and devices.

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We greatly appreciate your attention to our comments in response to the RFI. Should you have further questions regarding this information, please contact Peter Thomas or Taryn Couture, coordinators for the HAB Coalition, by e-mailing Peter.Thomas@PowersLaw.com or Taryn.Couture@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Habilitation Benefits Coalition

American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Cochlear Implant Alliance
American Occupational Therapy Association
American Speech-Language-Hearing Association
The Arc of the United States
Children's Hospital Association
The Christopher & Dana Reeve Foundation
National Association of Social Workers