



January 8, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-8016

RE: HHS Notice of Medicare Benefit and Payment Parameters for 2025 (CMS-9895-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association, I write to comment on the 2025 HHS Notice of Benefit and Payment Parameters proposed rule and its impact on health care consumers and providers through changes in federal requirements associated with the Affordable Care Act (P.L. 111-148).

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students.

ASHA and the Centers for Medicare & Medicaid Services (CMS) share a goal to improve health care coverage. While ASHA supports the majority of what CMS has proposed, we offer specific comments on the following topics:

- Essential Health Benefits (EHB)
- Network Adequacy
- Separating and Limiting Rehabilitation and Habilitation Caps
- Consumer Protections

### **Essential Health Benefits**

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“Rehabilitative and habilitative services and devices,” an essential health benefit category under current law, is key to ensuring functional independence for patients of all ages.<sup>1</sup> Rehabilitative 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. These services are key to enabling people with injuries, illnesses, and disabilities to:

- Improve, maintain, or slow deterioration of functional abilities and health status;
- Live as independently as possible;
- Return to work, family, and community activities as much as possible;
- Avoid unnecessary and expensive rehospitalization 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**. Many professions, including audiology and speech-language pathology, provide rehabilitative and habilitative services and devices in a variety of inpatient and 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 their ability to perform daily living activities in the most independent manner possible. They are highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

In the February 2015 Notice of Benefits and Payment Parameters Final Rule, 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.

ASHA supports preserving the regulatory definition of habilitative services and devices and related interpretations that have been duly promulgated and believes that this should be the *baseline* for all states in their implementation of essential health benefits (EHB). We encourage CMS to work with states to enhance implementation and enforcement of habilitation coverage. In addition, we urge CMS to reemphasize the following requirements and principles 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 credentials, 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, 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 on 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 of the regulation of “rehabilitation services and devices.” We view the fact that CMS codified a habilitation benefit definition in regulation but did not do so for rehabilitation services and devices as an oversight. 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, ASHA recommends 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.”*

#### EHB Benchmark Update Process Improvements

Under current policy, the cost of state benefit mandates 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 complexity of the current Medicare “defrayal” policy makes it difficult to understand and operationalize. ASHA supports CMS’s proposal to amend its rules to reflect that a covered benefit in the state’s EHB-benchmark plan is considered an EHB. Therefore, 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; 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 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).

Therefore, states would only need to assess two typical employer plan options (the most and least generous available). **ASHA supports these updates to the EHB benchmark process as we believe they would 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*

Dental coverage and access to dental services are essential to good oral and overall health. In 2021 the World Health Organization approved a Resolution on Oral Health stating that oral health care interventions should be included in universal health coverage programs.<sup>ii</sup> Poor oral health is linked to respiratory, cardiovascular, and other avoidable diseases in the adult population and can negatively impact the ability to chew and swallow; thereby, severely limiting an individual's quality of life.<sup>iii</sup>

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 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.

**ASHA supports this proposal, under which states seeking to improve access to oral health care 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 commonsense proposal that would ensure adults are able to access and receive the dental care they need and deserve.

#### **Network Adequacy**

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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. 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 of workforce shortages or geographical challenges, in order to be certified.

In addition, ASHA encourages CMS to explore appointment wait time standards for audiology and speech-language pathology similar to those proposed in the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P) proposed rule for outpatient mental health and substance use disorders (SUD), primary care, and obstetrics and gynecology (OB/GYN).

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 25% of SBMs and SBM-FPs do not have quantitative standards for network adequacy of Marketplace plans. SBMs and SBM-FPs that have its 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 should be subject to remedial action by CMS under its program integrity authority.

People with hearing, speech, language, cognition, balance, and/or swallowing disorders should have access to condition-specific specialists and services in settings that are physically accessible, and with a choice of providers no matter which qualified health plans (QHPs) they are enrolled in. **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.** Network adequacy standards should ensure that enrollees 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 habilitative and rehabilitative services and devices.

### **Separating and Limiting Rehabilitation and Habilitation Caps**

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In January 2023, ASHA responded to CMS's Request for Information (RFI) on EHBs.<sup>iv</sup> Our comments focused on ways to improve the rehabilitative and habilitative benefits by separating and limiting the therapy caps associated with both benefits. We continue to recommend 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 for patients to gain 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 soon 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. **ASHA recommends that CMS 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 ACA plan enrollees have access to critical therapy services when they are determined to continue to be medically necessary.**

**ASHA 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. 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, and 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 who requires physical therapy (PT) for muscle weakness, speech-language therapy 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, 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, ASHA 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 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 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, ASHA 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. The “SZ” modifier was deleted effective January 1, 2018, and the two new modifiers below became the only mechanism left to identify habilitation vs. rehabilitation.

- **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. **ASHA 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 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, 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.

## **Consumer Protections**

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### *Standardized vs. Non-Standardized Plan Options*

As ASHA highlighted in our 2024 comments it is not uncommon for health plans to manipulate consumer choice by creating a plethora of near-similar health plans that exploit search engine optimization and alphabetical listing on [healthcare.gov](https://www.healthcare.gov) to gain market share.<sup>v</sup> This is not in the best interests of consumers.

ASHA appreciates the goals of mitigating choice overload by limiting the number of non-standardized plan options that QHP issuers may offer through the Exchanges to two non-standardized plan options per product network type and metal; however, we are concerned that this arbitrary limit could have a chilling effect on innovation in marketplace health plans. Instead, ASHA supported the proposed meaningful difference standard that would allow for unique, innovative, and specialized plan design while limiting the risk to consumers.

While the proposed meaningful difference standard was not finalized in the 2024 final rule, **ASHA supports the proposed exceptions process to limit the number of non-**

**standardized plan options that issuers can offer to promote consumer access to plans with design features that facilitate the treatment of chronic and high-cost conditions, while continuing to reduce the risk of plan choice overload.**

*Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220(h))*

**ASHA supports the proposal to ensure that minimum HHS standards governing web-broker non-exchange website display of standardized QHPs comparative information, disclaimer language, information on eligibility, standards of conduct, and access by web-broker downstream agents and brokers apply to web-brokers across all Exchanges.**

A 2017 study revealed that low health literacy may occur even among well-educated patients and suggests that a majority of patients in the free clinic studied had trouble comprehending and following through on health information.<sup>vi</sup> Many patients stated their greatest challenge was completing the required forms for entitlement programs including Medicare and Medicaid.<sup>vii</sup> Given the prevalence of low health literacy and the fact that health literacy is frequently associated with social and economic factors that reinforce health inequities, health literacy is truly a health equity issue.<sup>viii</sup> ASHA is a strong advocate for comprehensive access to and coverage of audiology and speech-language pathology services, and favors maximizing pathways to enrollment by ensuring web-based information meets minimum HHS standards.

### 1332 Waivers

Health care innovations that promise improved patient care, improved provider experience, and reduced health care costs should be explored, trialed, and open for public comment to ensure transparency. Therefore, **ASHA supports the provision that would allow states the flexibility to hold a state public hearing or post-award forum in a virtual format (that is, one that uses telephonic, digital, and/or web-based platforms), or hybrid format (that is, one that provides for both in-person and virtual attendance), which would be considered as the equivalent of holding an in-person meeting.** Transparent and open dialogue—available to the largest possible number of stakeholders—will facilitate increased state innovation, which could lead to more affordable health coverage for individuals and families in states that consider implementing a Section 1332 waiver program.

Thank you for proposing important changes to the Notice of Benefit and Payment Parameters that will improve access to care for millions of Americans. ASHA appreciates the opportunity to provide comments and offer suggestions for further improvement. 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](mailto:rbowen@asha.org).

Sincerely,



Tena L. McNamara, AuD, CCC-A/SLP  
2024 ASHA President



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<sup>i</sup> Patient Protection and Affordable Care Act (“ACA”), 42 U.S.C., § 1302 *et seq.*

<sup>ii</sup> World Health Organization. Oral Health. Retrieved from <https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/oral-health>

<sup>iii</sup> Furuta M., Yamashita Y. (2013) Oral Health and Swallowing Problems. *Current physical medicine and rehabilitation reports*. 1(4):216-222. doi: 10.1007/s40141-013-0026-x. PMID: 24392281; PMCID: PMC3873078.

<sup>iv</sup> <https://www.asha.org/siteassets/advocacy/comments/asha-comments-to-cms-on-ehb-rfi-012723.pdf>

<sup>v</sup> <https://www.asha.org/siteassets/advocacy/comments/asha-comments-to-cms-on-nbpps-012723.pdf>

<sup>vi</sup> Sandra D. Lane PhD, Sally J. Huntington PhD, Lynn-Beth Satterly MD, Robert A. Rubinstein PhD, Robert H. Keefe PhD & Amax Project Student Researchers (Brian Buckley, Caitlin Cornell, Alyssa Fuller, Eric Hojnowski, Ryan LaFollette, Yelena Livshits, Todd Michaelis, Claire Motyl, Tarakad Ramachandran, Devan Rahmachandrin, Sofia Seckler, Evaline Tso, and Kate Zmijewski–Mekeem) (2017) Filling out the forms: Health literacy among the uninsured. *Social work in health care*. 56:8, 686-699, DOI: 10.1080/00981389.2017.1331947.

<sup>vii</sup> *ibid.*

<sup>viii</sup> Lopez, C., Kim, B., Sacks, K. (2022). Health Literacy in the United States: Enhancing Assessments and Reducing Disparities. *Milken Institute*. [https://milkeninstitute.org/sites/default/files/2022-05/Health\\_Literacy\\_United\\_States\\_Final\\_Report.pdf](https://milkeninstitute.org/sites/default/files/2022-05/Health_Literacy_United_States_Final_Report.pdf).