ASHA
American
Speech-Language-Hearing
Association

March 13, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: HHS Notice of Medicare Benefit and Payment Parameters for 2027 (CMS-9883-P)

Dear Administrator Oz:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to comment on the 2027 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 (ACA). We recognize the importance of the ACA, with nearly 50 million people having had ACA Marketplace coverage at some point.

ASHA is the national professional, scientific, and credentialing association for 247,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); 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. ASHA offers specific comments on the following topics:

- Program Integrity and Increased Eligibility Verification
- New Standards for Defrayal of State-Mandated Benefits
- Network Adequacy Standards and Oversight
- Rehabilitation and Habilitation Caps

Program Integrity and Increased Eligibility Verification

CMS proposes a robust set of program integrity provisions. ASHA strongly supports program integrity and opposes fraud, waste, and abuse in any form. However, we are concerned that certain proposed changes could unintentionally create administrative barriers for eligible individuals, particularly those with cognitive and/or communication disabilities who may face challenges navigating verification requirements.

Minor differences between information patients report on their marketplace health insurance applications and data from other trusted sources are common. When these data matching issues (DMIs) occur, the marketplace must ask for document resubmission to confirm application information. This process can create administrative burden for patients, who may need to resubmit detailed information about income, citizenship or immigration status, and other coverage.

For individuals with cognitive impairments, language disorders, and/or other communication disabilities, responding to verification requests and compiling documentation can be especially challenging. If they fail to submit acceptable documents by the deadline stated in the notice, they could lose coverage and/or premium subsidies, even when they are otherwise eligible.

CMS should carefully evaluate how the proposed provisions could increase the volume of DMI-related documentation requests. Increased administrative burden on both marketplaces and enrollees could reduce enrollment and disrupt coverage for eligible individuals.

Therefore, ASHA urges CMS to ensure that verification notices are clear and easy for consumers to understand. CMS should also streamline documentation requirements to reduce unnecessary administrative burden. Applicants must be given adequate time to respond to verification requests. In addition, CMS should monitor whether increased verification requirements result in eligible individuals losing coverage due to procedural issues rather than true ineligibility.

Program integrity efforts should be balanced with policies that ensure eligible individuals can reasonably navigate verification requirements and maintain or obtain coverage, including those with cognitive and/or communication disabilities.

New Standards for Defrayal of State-Mandated Benefits

Under current rules, CMS does not require states to defray the costs of state-mandated benefits if those benefits have been approved by CMS as part of the state's essential health benefit (EHB) benchmark plan. The proposed rule includes a provision that would consider certain state-required benefits to be in addition to EHBs, even if those benefits have been embedded in a state's EHB benchmark plan. Under the ACA, individual and small group market insurers must cover a minimum set of 10 categories of EHBs, including habilitative and rehabilitative services and devices. Examples of "in addition to" services can include hearing aids for adults or children, vision services, adult dental care, autism services, or other services.

ASHA is concerned that this proposal would reduce state flexibility to design plans that best serve their populations and could lead states to scale back or eliminate coverage for services that prevent more serious and costly complications. Many of these services support early intervention, rehabilitation, and long-term health management that reduce reliance on more expensive acute care.

The proposed rule would also prohibit issuers from including routine adult dental services as an EHB beginning with plan year (PY) 2027. Dental coverage and access to services are essential to good oral health. Poor oral health is linked to increased risk of respiratory illness, cardiovascular disease, and other preventable complications in the adult population, in particular. Oral health is also closely connected to communication, swallowing, and nutrition. SLPs treat individuals with communication and/or swallowing disorders (dysphagia), including older adults recovering from stroke or neurological disease. Poor oral health can impact functional communication and increase the risk of aspiration pneumonia—a leading cause of hospitalization among individuals with dysphagia. Therefore, allowing issuers to include routine adult dental services as an EHB is a common-sense proposal that would prevent downstream complications and costs to the health system.

ASHA urges CMS to preserve state flexibility in EHB benchmark design by allowing issuers to continue including routine adult dental services as part of EHB coverage and by maintaining current policy that does not require states to defray the costs of state-mandated benefits. These approaches support preventive care, help avoid costly hospitalizations and complications, and allow states to design coverage that meets the needs of their populations.

Network Adequacy Standards and Oversight

CMS proposes to give states greater discretion in provider access for network adequacy and Essential Community Provider (ECP) certification reviews. CMS also proposes to reduce the minimum percentage of ECPs—health care providers that serve low-income, medically underserved populations—that issuers must include in their networks from 35% to 20%. While states play an important role in overseeing marketplace plans, these proposed changes would place more responsibility on states and reduce federal oversight capability intended to ensure consistent access to care.

ASHA supports a strong federal framework that establishes minimum consumer protections while allowing states flexibility in implementation. Reducing federal network adequacy standards could limit federal oversight that ensures that health plans provide a sufficient choice of contracted providers, including ECPs. Patients seeking audiology and speech-language pathology services often experience long waitlists in their communities. In certain regions, limited availability also forces patients to travel to obtain timely care. This revision could result in decreased access to health care for all and make it more difficult for consumers to make accurate comparisons between plans.

ASHA also urges caution regarding telehealth access as a factor in meeting network adequacy requirements. While telehealth is an important tool that can expand access for many patients, ASHA stresses that telehealth should supplement, not replace, adequate in-person network providers. Although many audiology and speech-language pathology services can be delivered via telehealth and are widely covered by Medicare, Medicaid, and private health plans, not all services are appropriate for remote care. In addition, some patients and clinical situations are not well-suited for telehealth evaluation or treatment.

Therefore, ASHA recommends that CMS urge health plans to use telehealth modifiers to more clearly identify and designate telehealth services. Both the modifier 95, established by the American Medical Association through the Current Procedural Terminology (CPT) process, and the GT modifier, established by CMS, designate services provided via telehealth. Broader adoption of these modifiers affixed to CPT codes submitted on claims could lead to a better understanding of how telehealth is used to meet consumer needs and help determine how telehealth can appropriately supplement network adequacy standards to best meet consumer needs.

The adequacy of a plan's provider network can impact enrollees' access to benefits. Currently, 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. CMS has noted in past proposed rules that many marketplace plans come with narrow provider networks, resulting in potential access challenges for enrollees. Network adequacy standards should ensure that patients are not burdened by having to travel significant distances to receive covered services under a plan.

Individuals with hearing, cognitive, swallowing, and communication disorders often require specialized care from audiologists and SLPs. People with disabilities should have access to disability-specific specialists and services in settings that are physically accessible and have a choice of providers—primary, specialty, and subspecialty—no matter what qualified health plan they are enrolled in.

We believe that the adequacy of a plan's provider network dictates the level of access to covered benefits. If a plan covers a benefit but limits the number of providers or specialists, coverage may be effectively curtailed due to lack of access to providers with sufficient expertise to treat the patient.

Considering these concerns, robust network adequacy standards at the federal level must be strongly enforced. It is essential that Americans have access to affordable and meaningful coverage of habilitative and rehabilitative services and devices through the marketplace. Therefore, ASHA urges CMS to maintain robust federal network adequacy requirements while continuing to allow states flexibility in how they implement and oversee these protections.

Rehabilitation and Habilitation Caps

As discussed at our meeting with the Center for Consumer Information and Insurance Oversight (CCIIO) as part of the Habilitation Coalition on September 17, 2024, and again on December 3, 2025, ASHA remains concerned with EHB benchmark benefit limits (herein referred to as "therapy caps"). During these discussions, we raised the idea of eliminating therapy caps across the board or, alternatively, requiring or urging ACA plans that impose therapy caps to implement mechanisms to ensure patient access to medically necessary therapy once they reach a cap, such as an exceptions process similar to the one used by the Medicare Part B program.

ASHA is concerned that therapy caps do not consider individual clinical needs and can create challenges for patients who require ongoing habilitative or rehabilitative services and devices. In some cases, caps may unintentionally restrict access to medically necessary care for individuals with disabilities or complex medical conditions.

ASHA responded to CMS' Request for Information (RFI) on EHBs in January 2023. Our comments focused on ways to improve the rehabilitative and habilitative benefits by separating and limiting the therapy caps associated with both. Specifically, in our comments, and as outlined again below, we recommended that CMS adopt the approach Medicare used to address the outpatient therapy caps under that program. Medicare finalized that policy in 2017 to create a therapy cap exceptions process so patients can access the medically necessary rehabilitation services they need once they reach the therapy caps (habilitation is not covered by the Medicare program).

Our top goal is to eliminate therapy caps altogether for medically necessary care, especially for rehabilitative and habilitative services and devices. However, given the ACA's statutory allowances of non-dollar caps in benefits, and in light of our previous advocacy efforts with CCIIO on this issue that have not generated regulatory interest in this approach, we believe an exceptions process similar to the one imposed by Congress on the Medicare program is a meaningful alternative worthy of serious consideration for ACA plans. Ensuring that plans include workable exceptions processes would help maintain appropriate access to services while supporting responsible program administration and avoiding more costly health implications that can arise when needed services are delayed or interrupted.

We are hopeful that CMS will address some of our concerns mentioned in response to the EHB RFI or past Notice of Benefit and Payment Parameters proposed rules. However, to date, neither CMS nor CCIIO has provided any such response. Given this trend, at the very least, we urge CMS and CCIIO to include another RFI or some opening for stakeholder feedback on this topic in next year's Notice of Benefit and Payment Parameters proposed rule.

Reiterated ASHA Recommendations From January 2023 Response Letter to CMS' RFI on EHBs[1]

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, like 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 a certain number of visits per year (e.g., 20 visits). Caps and limitations in therapy benefits are not evidence-based. Therapy caps as restrictive as 20 visits per episode of care are largely based on the typical orthopedic patient who may fare well with the scope of this therapy benefit. 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 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 or 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 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 ensure that Medicare beneficiaries receive appropriate access to medically necessary therapy services.

If a repeal of therapy caps in ACA plans across the board—our preferred regulatory approach—is not an option, CMS should move forward with a requirement on all ACA plans that if such plans employ the use of visit limits in outpatient rehabilitation or habilitation therapy services, the plans must adopt an exceptions process similar to the process established under the Medicare program to ensure that ACA plan enrollees can get access to critical therapy services when they are determined by their treating practitioner to continue to be medically necessary.

In addition, ASHA strongly encourages 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 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 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 60-year-old tennis player who needs 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.

To further clarify the significant differences between habilitation and rehabilitation benefits—particularly among young individuals who may need multiple 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, they should be imposed separately for habilitation services and habilitation devices. 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 lifelong therapeutic visits.

ASHA also recommends that if ACA plans employ the use of benefit caps or limits, then the plans should be required to use separate visit caps for PT, OT, and speech-language pathology. 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 PT to gain core strength due to neck 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 exceed their 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.

Potential Section 504 and 1557 Considerations

We believe arbitrary therapy caps of all types disproportionately impact 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. 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." We believe the fact that 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) is persuasive evidence that these 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 we 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, 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 test some of these plans to make sure they are meeting patient needs, especially considering the pervasive lack of clinical evidence for therapy caps.

Habilitation and Rehabilitation Cap Modifiers

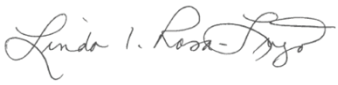
Finally, to clearly differentiate habilitative and rehabilitative visits and services, ASHA encourages the use of the separate habilitation and rehabilitation modifiers as were added in Appendix A of the 2018 Current Procedural Terminology (CPT®) code book. In 2017, the most common method for tracking 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 types 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 distinguish between habilitation and 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.”[2]

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 rehabilitative services (96 and 97, respectively) by all qualified health plans 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 determine the availability of these services and any potential barriers to access or imbalances between coverage of rehabilitation and habilitation services and devices.

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.

Sincerely,



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2026 ASHA President

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[1] American Speech-Language-Hearing Association. (2023, January 27). *Request for Information; Essential Health Benefits*. https://www.asha.org/siteassets/advocacy/comments/asha-comments-to-cms-on-ehb-rfi-012723.pdf

[2] American Medical Association. (2025). *CPT 2026 Professional Edition*. American Medical Association. https://www.ama-assn.org/practice-management/cpt/cpt-coding-resources