



November 12, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

RE: HHS Notice of Medicare Benefit and Payment Parameters for 2026 (CMS-9888-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to comment on the 2026 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). We recognize the importance of the Affordable Care Act (ACA) with nearly 50 million people having had ACA Marketplace coverage at some point.

ASHA is the national professional, scientific, and credentialing association for 234,000 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. While ASHA supports the majority of what CMS has proposed, we offer specific comments on the following topics:

- Public Reporting on Exchanges
- Quality Improvement Strategy (QIS) Data
- Telehealth and Health Equity
- Rehabilitation and Habilitation Caps.

### **Public Reporting on Exchanges (§ 155.1200)**

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ASHA is a strong proponent of the judicious use of CMS dollars for medically necessary, high-quality, and patient-centered care. Therefore, we applaud CMS' efforts to increase transparency and encourage program improvements through the public reporting of data shared through the State Marketplace Annual Reporting Tool that is currently used for performance and compliance monitoring purposes. Similarly, we are in favor of public reporting of (1) financial and programmatic audits; (2) documentation of corrective actions or open findings; and (3) metrics on state exchange operations and functionality. Transparency and public awareness are essential to maintaining appropriate high-quality care in an environment of utilization management for cost-cutting purposes. As seen in the recent Senate Permanent Subcommittee on Investigation's report titled *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care*, decisions are often made based on financial and administrative mandates, not clinical

recommendations. Public reporting will assist beneficiaries in making the best possible choice for their own health care needs.

### **Quality Improvement Strategy (QIS) Data (§ 156.1130)**

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Similarly, ASHA supports the public reporting of aggregated, summary-level Quality Improvement Strategies (QIS) data to drive innovation and advance quality improvement across the exchanges, including: (1) value-based payment models used in Qualified Health Plans (QHPs) offered by the issuer; (2) QIS topic area; (3) QIS market-based incentive types; (4) clinical areas addressed by QIS; (5) QIS activities; and (6) Quality Rating System measures used in QIS.

Audiologists and SLPs, like most clinicians, are challenged by administrative burden in addition to heavy clinical loads. Therefore, ASHA supports public reporting of QIS data as part of CMS efforts to strengthen alignment across its quality reporting and value-based incentive programs.

ASHA broadly supports the priorities of the CMS National Quality Strategy for Quality Improvement in Health Care and shares the vision of having a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care. As nonphysician qualified health providers, audiologists and SLPs have had limited opportunity to participate in alternative payment models and other value-based care initiatives to date. We are eager to explore, refine, and develop models that create an avenue for nonphysician qualified health provider participation.

ASHA encourages CMS to consider how it can develop models that incorporate all members of multidisciplinary care teams. This could be achieved by expanding existing models, including the applicable quality metrics, or developing new models focused on nonphysician practitioners. As currently structured, many of the approved models are physician-driven and focused on the entire episode of care. The quality measures often do not capture the services of nonphysicians such as audiologists and SLPs, so there is no incentive for physicians to incorporate these specialties into the model. Audiologists and SLPs are also not responsible for managing the full range of services a patient may need but could be held accountable for the cost of care associated with the types of communication interventions they provide. We hope CMS will consider if it can develop models that capture the quality and cost associated with nonphysician services to ensure it is achieving its goal of improving the quality of care patients receive and protecting the Medicare trust fund, as the value of any quality program depends on the ability of all providers to participate.

### **Telehealth and Health Equity**

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One of the most significant advancements in promoting health equity is the expanded use of telehealth services. Telehealth has proven to be a vital tool in improving access to care for individuals in rural and underserved areas, as well as for patients managing chronic conditions. The COVID-19 pandemic demonstrated the critical role telehealth can play in mitigating barriers to care, and we believe it should continue to be a cornerstone of patient care.

We recommend, in future rulemaking, that CMS require QHPs to report on the availability and utilization of telehealth services, broken down by specialty, geographic location, and demographic factors such as income and race/ethnicity. This data will help CMS and stakeholders assess whether telehealth is effectively addressing health disparities and highlight areas where additional telehealth services or in-person care may be needed to close gaps in access. While telehealth is a powerful tool for improving access, it is not a substitute for all types of care. CMS should ensure that patients continue to have access to in-person services, particularly for diagnostic tests, physical exams, and other care that cannot be delivered virtually. We also recommend that CMS ensure that telehealth platforms are fully compliant with Americans with Disabilities Act (ADA) standards and that they offer language interpretation services to meet the needs of individuals with disabilities or language barriers.

### **Rehabilitation and Habilitation Caps**

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As discussed at our meeting with the Center for Consumer Information and Insurance Oversight (CCIIO) as part of the Habilitation Coalition on September 17, ASHA remains concerned with essential health benefit (EHB) benchmark benefit limits (herein referred to as “therapy caps”). During our meeting, we discussed 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 a cap has been reached, such as an exceptions process similar to the one used by the Medicare program. We view these caps as arbitrary, discriminatory in a manner that has a disproportionate impact on individuals with disabilities, and short-sighted given the long-term, unnecessary costs created by a lack of access to appropriate rehabilitation and habilitation services and devices.

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 rehabilitation and habilitation benefits. Specifically, in our comments from January, and as outlined again below, we recommended 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 so patients can access the medically necessary rehabilitation services they need once the arbitrary therapy caps are reached (habilitation is not covered by the Medicare program).

Our top goal is to eliminate arbitrary 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.

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.

### **Restated ASHA Recommendations From January 2023 Response Letter to CMS' RFI on EHBs<sup>1</sup>**

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 an arbitrary number of visits per year (e.g., 20 visits). Caps and limitations in therapy benefits are not evidence-based. They are imposed by health plans to save money, plain and simple, regardless of medical necessity. Therapy caps as restrictive as 20 visits per episode of care are largely based on the typical orthopedic patient who may 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 the ACA plan enrollees' access to both rehabilitation and habilitation services and devices.

As already stated, rehabilitation therapy caps were created with the typical orthopedic adult in mind. For instance, a joint replacement or other common orthopedic procedure typically requires outpatient therapy of moderate duration, intensity, and scope. However, habilitation benefits are 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 and any cap or limitation should start anew with each specific reason or condition for habilitation therapy intervention. As this example demonstrates, a habilitation benefit limitation based on a rehabilitation benefit for acute illness or injury will often be seriously insufficient to support this child as they grow, develop, acquire new skills, and achieve new and more advanced functional milestones. The habilitation benefit should be designed with the intent to recognize and allow for frequent and 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 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 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 Concerns***

We believe arbitrary therapy caps of all types disproportionately discriminate against individuals with disabilities. The therapy caps imposed under the ACA raise serious concerns under Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the ACA. 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 CCIO 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 in light of the pervasive lack of clinical evidence for therapy caps.

### ***Habilitation and Rehabilitation Caps Modifiers***

Finally, 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 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.”

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.

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>1</sup> 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>.