



January 27, 2022

ELECTRONIC SUBMISSION VIA www.regulations.gov

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

**RE: HHS Notice of Benefit and Payment Parameters for 2023 (CMS-9911-P;
RIN: 0938-AU65)**

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2023 (NBPP)¹. Given the importance of this annual rulemaking, and the significant impact the NBPP regulations have on enrollees in the exchanges, we urge CMS to establish at least a 60-day comment period to ensure that stakeholders and advocates are able to appropriately consider and respond to provisions in future proposed rules.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the clinicians who serve them – who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

I. Rehabilitative Services and Devices under the ACA

The Affordable Care Act (ACA) includes statutory language that requires coverage of essential health benefits (EHBs), including one of ten categories of benefits known as “rehabilitative and habilitative services and devices.” Inclusion of this language in the statute was a major milestone for the rehabilitation and disability community, in that Congress recognized the importance of these benefits to improve the health and functioning of the American people.

¹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584 (Jan. 5, 2022).

In the NBPP final rule for 2016², CMS defined “rehabilitation services and devices” as follows:

“Rehabilitation services and devices – Rehabilitative services, including 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.”

For the first time, this regulation established a uniform definition of rehabilitative services and devices that states and health plans could understand and consistently implement. This definition became a standard for private insurance coverage and a floor of coverage for individual insurance plans sold on the exchanges. Importantly, the definition includes both rehabilitative services and rehabilitative devices. The adoption of a federal definition of rehabilitation services and devices minimized the variability in benefits across states and uncertainty in coverage for children and adults in need of medical rehabilitation and post-acute care. The rehabilitation and habilitation benefits under the ACA have been critical to ensuring that individuals with injuries, illnesses, disabilities, and chronic conditions are able to access the care they need. We appreciate the agency’s commitment to maintaining these benefits and supporting enrollees in this proposed rule.

II. Ensuring Meaningful Network Adequacy

In the rule, CMS proposes to codify new standards and methodologies to evaluate network adequacy for qualified health plans (QHPs) in the federally facilitated exchanges (FFE). The adequacy of a plan’s provider network can greatly impact the level of access to benefits for enrollees. For individuals enrolled in a QHP to benefit from appropriate rehabilitation, CPR believes that issuers must adhere to patient-friendly network adequacy standards that provide ample access to the full complement of rehabilitation and habilitation service and device providers, professionals, and facilities that provide both primary and specialty care. These services should be provided based on the individual’s needs, prescribed in consultation with an appropriately credentialed clinician, and based on an assessment by an interdisciplinary rehabilitation team and a resulting plan of care.

CMS proposes to codify the list of provider and facility specialty types subject to the network adequacy reviews. CMS does *not* propose to include post-acute rehabilitation programs, such as inpatient rehabilitation hospitals and units (IRFs), comprehensive outpatient rehabilitation facilities (CORFs), or long-term care hospitals (LTCHs) in the list of facility specialty types evaluated during these reviews. These are critical settings of care for rehabilitation services and devices and their omission in network adequacy reviews is a glaring omission in this proposed rule. This is illustrated by the fact that CMS includes IRFs and CORFs as a covered benefit under traditional Medicare, and hundreds of thousands of Medicare enrollees benefit from treatment from these providers on an annual basis. **CPR strongly urges CMS to include IRFs, CORFs, and LTCHs as part of the agency’s network adequacy review process.**

² Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10749 (Feb. 27, 2015).

Ensuring the availability of a wide range of rehabilitation provider types will help ensure that enrollees have access to the appropriate intensity and scope of needed rehabilitation services. For instance, too often enrollees across the country may be diverted into nursing homes rather than IRFs because their health plans do not contract with a sufficient number of rehabilitation providers. Too often, enrollees with brain injuries, spinal cord injuries, those who have sustained strokes, and others with a variety of complex but common conditions do not receive the intensive, longer-term services they need because health plans do not contract with specialized brain treatment programs. Further, inadequate specialty networks exacerbate health equity issues for patients who are already facing disparities in access to health care.

CMS also proposes to set maximum time and distance standards for the providers and facility specialty types subject to network adequacy standards. **Network adequacy standards should ensure that people with injuries, illnesses, disabilities, and chronic or complex conditions are not burdened by significant traveling distances in order to receive covered services under the plan and should recognize that many people with disabilities lack transportation options.**

III. Network Adequacy and Telehealth

CMS proposes to require all issuers seeking certifications of plans to submit information about whether network providers offer telehealth services. The agency states that this data would not be made public and would be intended for information purposes only. In the Medicare Advantage program, CMS has allowed MA organizations to receive a “credit” towards the percentage of enrolled beneficiaries residing within the applicable time and distance to meet network adequacy standards, if the MA organization contracts with telehealth providers for certain specialties. While CMS clearly states in this rule that the agency is *not* proposing such a policy for plan year 2023, the rule does seek comment on whether the network adequacy standards for exchange plans and MA plans should be aligned, particularly citing the telehealth credit approach used in the MA program.

CPR appreciates that the rapid expansion of telehealth during the COVID-19 pandemic has allowed many beneficiaries, whether covered through the exchanges, Medicare, Medicaid, or other payers, to safely access medically necessary health care while protecting themselves from threat of infection with COVID-19. Further, the ability to receive medical services, including medical rehabilitation, virtually has provided tremendous benefit to many people with disabilities beyond abiding by social distancing protocols, including easing the complications associated with planning, transportation, and accessibility of in-person visits and the potential to cut down on distractions and hurdles associated with receiving care in an unfamiliar environment. We also note that the proliferation of telehealth may allow patients to receive more stable, continuing access to therapy and other important services. **We support increased access to care through the use of telehealth, as long as it does not come at the expense of providing face-to-face health care services when in-person services are necessary, preferred by the patient, or would enhance the quality of care to people with disabilities.**

It is critical that expansion of telehealth services, and policies encouraging such expansion, does not limit patients' access to in-person care, especially when the services needed by the patient are more effectively and efficiently provided in-person. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions often need the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is crucial that beneficiaries receiving rehabilitation care are able to access the most appropriate care in the most appropriate settings.

People with disabilities should have access to disability-specific specialists and services, in settings that are physically accessible, and with a choice of providers – primary, specialty, and subspecialty. CPR believes 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. In light of these concerns, CMS must ensure robust network adequacy standards that fully protect access to both in-person and virtual care – and these standards must be strictly enforced. It is essential that Americans have access to affordable and meaningful coverage of rehabilitative services and devices to which they are entitled.

IV. Promoting Broader Use of Rehabilitation and Habilitation Modifiers

Beginning in 2017, the ACA mandated all individual and small-group, non-grandfathered health plans that utilize visit limits to have separate limits for rehabilitative and habilitative services.³ This requirement is critical to ensuring that enrollees have sufficient access to both benefits, which may incorporate similar services but are distinct in therapeutic purpose. To appropriately administer the separate visit limits, clinicians and plans need to identify whether a provided service is rehabilitative or habilitative.

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 were added in Appendix A of the 2018 CPT code book⁴ and can be added to the appropriate CPT codes on claims submitted to ACA-compliant and other health insurance plans:

- **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

³ 2016 NBPP at 80 FR 10811.

⁴ © American Medical Association.

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. They do *not* replace the -SZ modifier (habilitative services) developed by CMS and used by many non-Medicare payers. **CPR encourages CMS to develop policies, whether through the final NBPP for 2023, other regulations, or subregulatory guidance, to encourage use of these CPT modifiers for rehabilitative and habilitative services 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.**

Better data collection, made available to stakeholders and the public, will illuminate whether future policy changes must be made to protect access to these services, including to ensure that the requirement for separate limits on rehabilitation and habilitation services is being followed. In keeping with the Department’s focus on evidence-based practice, future regulations governing the rehabilitation benefit must rest upon a strong foundation of data, which can be bolstered with the improved use of the rehabilitation and habilitation modifiers.

V. Use of Evidence-Based Standards

CMS proposes to refine the EHB non-discrimination policy to “ensure that benefit designs, and *particularly benefit limitations* and plan coverage requirements, are based on clinical evidence.” [Emphasis added.] CMS proposes to define appropriate evidence to include peer-reviewed articles in medical journals, clinical practice guidelines, and recommendations from reputable governing bodies. **We greatly appreciate the focus on preventing discriminatory benefit limitations and encourage CMS to emphasize that these new requirements should not be used to deny coverage for treatments.** Instead, plans that impose restrictions such as visit limits and caps for rehabilitation therapy should be required to present sufficient clinical evidence to justify these constraints, protecting enrollee’s access to care.

Rehabilitation is a particularly complex field, with wide variations in complexity and outcomes even within seemingly narrowly defined conditions. In many cases, it is difficult to develop a gold standard of clinical evidence for rehabilitation through double-blinded studies and clinical trials, which in some cases raise ethical concerns. For example, a 2012 report from the Agency

for Healthcare Research and Quality (AHRQ)⁵ on rehabilitation for traumatic brain injury (TBI) found that comparative effectiveness research on TBI rehabilitation was limited but noted that the “failure to draw broad conclusions must not be misunderstood to be evidence of ineffectiveness.” Further, the study authors contended that rigorously conducted systematic reviews, the “gold standard” of clinical evidence, represent a “high bar currently met by only a small portion of medical interventions (and an even smaller portion of rehabilitation interventions.)”

The proposed rule’s call for evidence-based benefit coverage must not be interpreted by plans to create an overly rigid evidentiary standard. If this regulatory language is deployed inappropriately, it may limit beneficiary access to care, especially with respect to complex, chronic, or uncommon conditions that may not have a wide range of high-quality evidence supporting particular courses of treatment. We recognize the importance of CMS’ protections against discriminatory benefit design, and on behalf of the rehabilitation community, encourage the agency to protect patients’ access to the essential benefits to which they are entitled.

We greatly appreciate your consideration of our comments on the 2023 Notice of Benefit and Payment Parameters proposed rule. Should you have any further questions, please contact Peter Thomas and Joe Nahra, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Association of University Centers on Disabilities

⁵ Brasure M, Lamberty GJ, Sayer NA, et. al. Multidisciplinary Post-Acute Rehabilitation for Moderate to Severe Traumatic Brain Injury in Adults. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2007-10064-I.) AHRQ Publication No. 12-EHC101-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2012. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Brain Injury Association of America*

Center for Medicare Advocacy*

Christopher & Dana Reeve Foundation*

Disability Rights Education and Defense Fund

Falling Forward Foundation*

Lakeshore Foundation

National Association for the Advancement of Orthotics and Prosthetics

National Association of Social Workers (NASW)

National Association of State Head Injury Administrators

National Disability Rights Network (NDRN)

National Multiple Sclerosis Society*

Rehabilitation Engineering and Assistive Technology Society of North America

Spina Bifida Association

United Cerebral Palsy

United Spinal Association*

**** CPR Steering Committee Member***