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October 31, 2011

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9975-P
Mail Stop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule, File Code CMS-9989-P

Dear Administrator Berwick:

On behalf of our 82,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the proposed rules regarding the Establishment of Exchanges and Qualified Health Plans published in the *Federal Register* on July 15, 2011. APTA's goal is to foster advancements in physical therapy practice, research, and education. The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public. Physical therapists practice in a wide variety of inpatient and outpatient settings, including hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, physical therapist private practice offices, and physician offices in which health care will be delivered to Qualified Health Plan (QHP) enrollees.

The establishment of the state-level health insurance exchanges ("Exchanges") and QHPs will bring enormous change to the health insurance marketplace. This change will have a substantial impact on health care providers, including physical therapists. Notably, physical therapists will not only be impacted by the development of the Exchanges as health care providers but also as employers and owners of small businesses. Many physical therapists own and operate facilities, serving as an employer to office staff and other therapists. As previously mentioned, many of these facilities are small businesses, and in that capacity, are potential Small Business Health Options Program (SHOP) plan purchasers.

As representatives of physical therapists in their capacity as health care providers, employers and potential SHOP plan purchasers, APTA is very interested in the development of these regulations. We greatly appreciate the opportunity to provide our comments, and we look forward to working with CMS throughout the process of establishing the framework for the Exchanges through future rulemaking.

We strongly support the flexibility that the proposed rule provides to states to establish their Exchanges based on the diverse needs of their residents and insurance markets. APTA believes that this state flexibility will be crucial to achieve the vision of the Exchanges within the Patient Protection and Affordable Care Act (ACA), which is to streamline the purchase of health insurance and allow consumers to make better-informed decisions regarding their coverage.

Network Adequacy Standards (§ 155.1050)

Qualified Health Plan Network Adequacy Standards (§ 156.230)

APTA commends CMS on its attention to network adequacy standards within the proposed rule. We understand and support the need for some flexibility within the states to tailor QHP networks to the local market needs. However, we are concerned that the proposed rule standard is too broad and may be ripe for provider exclusions.

Section 155.1050 of the proposed rule merely provides that an exchange “must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.” We believe that this standard alone is not sufficient to ensure that enrollees have timely and geographically accessible care as well as access to sufficiently diverse provider types from diverse health care settings.

However, within the proposed rule, CMS also offered four potential additional requirements that were based on the NAIC Managed Care Plan Network Adequacy Model Act. These additional requirements include: (1) sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.

APTA supports these additional requirements. We believe that further delineation of the broad, ambiguous standard that currently exists in the proposed rule is essential to aid states in interpreting “sufficient choice of providers.” The addition of these requirements will still afford the Exchanges significant flexibility to create quantitative or qualitative standards to establish clear expectations of access to care. In addition, the Exchanges can and should further define what “unreasonable delay,” “reasonable proximity,” and “timely manner” will mean for their individual markets.

Our support and further recommendations for each additional requirement are explained below.

(1) Sufficient numbers and types of providers to assure that services are accessible without unreasonable delay.

QHPs should reflect the range of providers in a community to ensure enrollee choice and access to the most appropriate source of care. A wide range of providers is critical, as restricted patient access to any one provider type is insufficient to meet patient clinical needs across the continuum of care. To ensure that patients are receiving the high quality and cost-saving services mandated under the ACA, QHPs will need to provide the full spectrum of comprehensive services required by their patient populations. This includes services provided by physical therapists and other non-physician providers.

Sufficient Access to Physical Therapy

Importantly, the ACA requires that each QHP offer the essential health benefits (EHB) package. Within that EHB package, the statute explicitly requires coverage of rehabilitative services. Rehabilitative services should include physical therapy and be provided by qualified health care professionals. With respect to physical therapy services, these services should be provided by qualified health care professionals as defined in federal law (42 CFR Section 484.4). Therefore, because rehabilitative services are statutorily defined as “essential,” access to physical therapists will be of utmost importance to QHP compliance.

Additional Requirement Recommendation: Sufficient Number of Health Care Settings

In addition, APTA recommends that CMS require QHPs to include sufficient types of providers in a diversity of health care settings. Physical therapy services are provided in a variety of different settings, including hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, physical therapists’ private practice offices, and physicians’ offices. These different health care settings, in both acute and post-acute care, meet the clinical needs of a broad spectrum of patients, dependent on the severity and intensity of impairments. Patients should be placed into the appropriate setting to meet their needs based on their individual clinical characteristics and presentation. In addition, a variety of settings within the QHP network will offer greater choice for the enrollee to enhance access to care within a community. APTA is concerned that, without additional language in the proposed rule that requires a variety of settings for network adequacy, QHPs may inappropriately limit physical therapy coverage to only a few or just one health care setting.

For instance, we are concerned that the QHP may choose a large physician group practice that provides physical therapy services as the sole network provider of physical therapy over a smaller specialized physical therapy practice. Another concern is that a QHP may only allow coverage for outpatient physical therapy services furnished in an outpatient hospital department. It is important for enrollees to have the option to go to different

types of settings to receive their physical therapy services within the community to ensure patient access to care. Therefore, we recommend that this additional requirement contain the following additional language: “Sufficient numbers and types of providers **in a variety of health care settings** to assure that services are accessible without unreasonable delay.”

Services Accessible Without Unreasonable Delay

APTA has a long-standing commitment to achieve patient access to physical therapy without unreasonable delay. Preventive care and early intervention of physical therapy has been shown to result in more timely and cost-effective care as well as more profound functional outcomes. We support substantive changes in health care delivery models that combat existing patient struggles with costly and time-consuming delays in obtaining physical therapy services. For example, APTA supports direct access to physical therapy services as an underlying premise within the Exchanges. Direct access promotes greater efficiencies and timely access to a qualified physical therapist through models that do not require a referral from a physician or other health professional. This is an essential element of a patient-centered health care model.

(2) Arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients.

APTA supports this additional requirement regarding proximity because patients, particularly those with severe functional impairments, need access to multidisciplinary care close to home to avoid the burdens created by traveling substantial distances. In addition, the need for non-burdensome access to care, including physical therapy, becomes particularly important in rural, underserved areas. This additional requirement explicitly requires the state to address these potential geographic burdens. While the state will retain flexibility to interpret “reasonable proximity and accessibility” depending on the specific geographic and local needs, this additional requirement provides an added safeguard to guide the Exchange as it defines its own standards.

(3) An ongoing monitoring process to ensure sufficiency of the network for enrollees.

The evolving health care landscape demands an oversight mechanism that will ensure patients can continue to access the care they need. As the Exchanges gain more enrollees and as an area loses or gains providers, a monitoring process must be in place to ensure that the needs of the patient population are being met through the choice of providers offered within the QHP networks.

In addition, this oversight mechanism should ensure that the Exchanges adhere to the federal provider non-discrimination provision in the Affordable Care Act (ACA) (*See* Section 1201, Subpart 1, creating a new Public Health Service Act Section 2706, “Non-Discrimination in Health Care, 42 USC §300gg-5) slated to take effect January 1, 2014. This provision indicates that “a group health plan and a health insurance issuer offering

group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.”

Therefore, to ensure that Exchanges continue to provide the access to care that patients need through the appropriate providers after their establishment and to ensure compliance with federal provider non-discrimination laws, APTA fully supports the requirement that the Exchange have an ongoing oversight process that monitors network sufficiency for enrollees.

(4) A process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.

CMS offers a final potential additional requirement, providing a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible to provide that benefit in a timely manner. APTA supports this provision to accommodate specialty needs of enrollees. For example, patients with severe impairments and co-morbidities may have a need for heightened and specific expertise. A specialist may become necessary for these patients. Coverage should be available for specialty services that address the clinical needs of patients with severe conditions or impairments, even if they are not offered within the network.

Transparency in Coverage (§ 156.220, § 155.1040)

The proposed rule requires that “QHP issuers make available to the enrollee information on cost-sharing responsibilities for a specific service by a participating provider under that enrollee’s particular plan.” We believe that this transparency in enrollee benefits, particularly cost-sharing responsibilities, is extremely important for two reasons. First, transparency of benefits empowers enrollees to make educated decisions about their own care. This is another essential element of a patient-centered health care model. Second, cost-sharing responsibilities for patients seeking physical therapy services have become increasingly burdensome throughout the country, and many patients do not become aware of the burden until after the service was provided.

For example, co-pays in states such as New York and New Jersey have become so burdensome that they greatly limit access to physical therapy care for many patients. It is not at all uncommon for a co-pay to account for 60 to 90 percent of the maximum allowable cost-sharing responsibility on a visit. In fact, we have reports of instances in which there is a \$50 co-pay on a \$55 maximum allowable. This means that the patient is paying 90 percent of the cost, or \$50 per visit, while the insurer is paying only \$5 per visit. We believe that patients should be made aware of these burdens that inhibit access to important services, such as physical therapy. Therefore, we support these transparency requirements for QHP issuers and commend CMS’ attention to this important issue.

Stakeholder Consultation (§ 155.130)

We support CMS' proposal to expand the stakeholder groups with which the Exchanges must consult as they establish their programs and throughout the ongoing operations. The proposed rule lists "health care providers" now among the stakeholder groups that must be consulted. The APTA agrees that consultation with health care providers will be greatly important as Exchanges develop; however, we urge CMS to clarify that "health care providers" should include a broad diversity of providers, including non-physicians such as physical therapists. We believe the inclusion of non-physician providers such as physical therapists will expand information gathering on the appropriate operations of the Exchanges beyond traditional medical providers, which will be critical to represent the multidisciplinary approach to health care supported within the ACA.

Initial and Annual Open Enrollment Periods (§155.410)

In section 155.410(c), the proposed rule suggests effective dates of coverage for the initial open enrollment period based on the date the Exchange receives a QHP selection from an individual. The proposed effective dates for coverage for applications received on or after the 23rd of a month will result in gaps in coverage that we believe should be avoided. APTA recommends that coverage effective dates be flexible to avoid gaps in coverage. To achieve this, we suggest that the Exchanges allow the applicant to choose an effective date starting with the date of application, as is done in Medicaid, or in the alternative, the effective date starts on the first day of an upcoming month. Even though premium tax credits only apply for full month coverage, applicants should be given the option for immediate coverage at the full unsubsidized cost. This will limit avoidable gaps in coverage so that enrollees can continue to receive medically necessary health care.

Special Enrollment Periods (§155.420)

The proposed rule also provides requirements regarding effective dates of coverage for special enrollment period, which are similar to the effective dates for the initial and annual open enrollment period. Again, APTA recommends that effective dates of coverage are flexible during special enrollment periods because we believe that every effort must be made to avoid any gaps in coverage. In this case, the effective start date of coverage during a special enrollment period should be tailored to the circumstances of the triggering event in order to provide continuous coverage and avoid coverage gaps.

Eligibility Determination Process for SHOP (§ 155.715)

Because APTA represents physical therapists in private practice who may qualify to purchase coverage within the SHOP, we urge CMS to recognize the hardship that overly burdensome administrative process will have on small businesses such as physical therapy private practices.

For example, section 155.715 of the proposed rule sets forth the administrative process that a SHOP must follow if it has reason to believe that an employer is not eligible to participate in the SHOP Exchange. Under this process, employers and employees are subject to an eligibility review 30 days from the date of notice to provide evidence to support the application for SHOP eligibility. APTA fears this tight 30-day turnaround may be overly burdensome for small private practices with limited resources. Additionally, the proposed rule issued on August 17, 2011 regarding individual eligibility for the Exchange allows an individual 90 days from the date of notice to provide supporting evidence. It also provides the possibility of an extension to this 90-day timeframe if good faith effort is shown. (See Section 155.315(e)(2) in 76 FR 51232, August 17, 2011). We believe that the employer and employee SHOP applicants should be afforded this same 90-day period to provide additional required documentation.

Required Consumer Assistance Tools and Programs of an Exchange (§ 155.205) Navigator Program Standards (§ 155.210)

The proposed rule requires several consumer assistance functions, including a call center and an up-to-date website described in section 155.205, as well as the Navigator program described in section 155.210. APTA fully supports these consumer assistance tools that will aid our patients to make well-informed decisions regarding their coverage and health care. Frank, up-front communications about coverage, expected out-of-pocket expenses, and quality ratings serve as a means to the patient-centered health care end that was envisioned in the ACA.

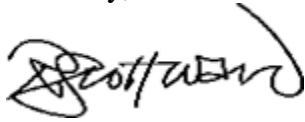
Privacy and Security of Information (§ 155.260)

Section 155.260 of the rule requires that the Exchange apply appropriate security and privacy protections when collecting, using, disclosing or disposing of personally identifiable information. Ensuring that personal information provided by enrollees in the Exchange and SHOP participants remains private is essential. Therefore, we support this requirement to establish privacy and security standards that are transparent, publically available and clear to all enrollees and SHOP participants.

Conclusion

APTA greatly appreciates the opportunity to comment on the Establishment of Exchanges and Qualified Health Plans proposed rule. We look forward to working with CMS to ensure that the framework for the Exchanges promotes patient-centered care, coverage of high quality services and seamless coordination throughout the health care continuum. If you have any questions regarding our comments, please contact Gillian Russell, Assistant Director, Regulatory and Payment Counsel, at 703-706-3189 or gillianrussell@apta.org.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Scott Ward". The signature is stylized with a large, sweeping initial "R" and a long, horizontal flourish extending to the right.

R. Scott Ward, PT, PhD
President

RSW:glr