

January 31, 2012

Submitted Electronically

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: The American Physical Therapy Association's Response to the Institute of Medicine's report, *Essential Health Benefits: Balancing Coverage and Cost*

Dear Secretary Sebelius:

On behalf of our 80,000 member physical therapists, physical therapist assistants, and students of physical therapy, The American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Department of Health and Human Services (HHS) in response to the Institute of Medicine's report entitled —*Essential Health Benefits: Balancing Coverage and Cost*, released on or around October 7, 2011. The following comments address some of the questions your office posed during the regional listening sessions held around the country.

Rehabilitative Services

Physical therapy services encompass the diagnosis of, interventions for, and prevention of impairments, activity limitations, and participation restrictions related to movement, function and health. (Guide to physical therapist practice, second edition. *Phys Ther.* 2001;81(1):9-746.) Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. Physical therapists are qualified to provide rehabilitative services, a defined category of essential health benefits by the Secretary of HHS. Physical therapy services are often a less costly, yet effective, treatment for conditions such as back pain, osteoarthritis and incontinence.

APTA is committed to advancing the safety and quality of healthcare and we are eager to work with the HHS and the states in promoting access to appropriate health care services in the current environment of states' resource constraints. Physical therapy is an essential service provided to adults and children under private and public insurance programs. APTA supports the practitioner's ability to deliver individualized patient care that is medically necessary by providing a range of benefits to choose from to optimize health outcomes. These services are crucial to improving a beneficiaries' ability to function, participate in daily living, maintain productivity and improve the quality of their health outcomes. In this current environment of practitioner shortages, it is imperative that vulnerable populations, such as those who will be participating in the Affordable Health Insurance Exchanges ("Exchanges") be able to access the appropriate health care services - including physical therapy - and practitioners that they medically require. APTA also realizes that the determination of the essential health benefits that are offered on the Exchanges involves balancing a practitioner's ability to choose the appropriate medically necessary services in a cost effective way. We urge the Secretary to refrain from defining the scope of benefits too narrowly as it could impede a practitioner's ability to choose from the most appropriate treatment based on the individual's unique medical needs. At the same time, we realize that these services must be delivered within fiscally responsible constraints to control health care expenditures.

"Essential" Benefits

"Essential," in the context of essential benefits provided under insurance plans, should mean benefits that are available and accessible to all individuals with coverage without increased premiums and co-payments. Essential benefits include, but are not limited, to preventing the spread of disease, improving and/or eradicating certain medical conditions or disease states, improving and minimizing the effects of acute and chronic conditions, injury prevention, health benefits which promote and encourage healthy behaviors and mental health, and assuring quality and accessibility to these services. Without such essential benefits, an individual's health condition would deteriorate and potentially require even more costly healthcare resources.

Under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA), rehabilitative and habilitative services and devices are included as a category defined as "essential." Generally, rehabilitative services may include:

- * Diagnosis and management of movement dysfunction and human performance to enhance physical and functional abilities;
- * Skilled interventions to address functional limitations, impairments and disabilities that diminish an individual's quality of life, health status, or independence in activities of daily living. Restoration, maintenance and promotion of optimal physical function; and
- * Prevention and management of the onset, symptoms, and progression of impairments, functional limitations and disabilities that may result from disease, disorders, conditions or injuries.

Essential rehabilitation services are also those that are necessary for the establishment of a safe and effective maintenance program for the patient. *42 C.F.R. §409.44(c)(2)(iii)*. The fact that the administration of therapeutic services has stabilized an individual's condition does not render cessation of care. The option of continuing physical therapy in certain situations - such as an individual's fragile health state becoming stabilized through rehabilitative services - becomes an essential health service so that an individual's health does not continue to deteriorate. Rehabilitative services should be provided by qualified health care professionals currently authorized under federal law (*42 CFR § 484.4*), such as physical therapists.

The determination of precisely which type of rehabilitative services should be provided to the individual should not be restricted by additional limiting definitions of what rehabilitative services are or which rehabilitative services are "essential." Insurers should not be able to set "rules of thumb" that limit the provision of rehabilitative services in their plans or policies. The determination of what type of rehabilitative services should be provided should be made based on the results of the initial evaluation by the individual's qualified health care provider on a case-by-case basis. Any further limiting language in the determined essential health benefits categories could impinge upon the health care provider's ability to provide the best quality of care for the patient's particular condition.

We caution restricting the number of therapy visits in essential health benefits packages without allowing for an exceptions process for several reasons. In most insurance plans, the number of physical therapy visits allowable per year are routinely combined with speech and occupational therapy visits. This can be problematic for conditions such as stroke. Often, an individual who sustained a stroke has deficits in many areas, such as speech (aphasia), mobility, and function requiring the skills and interventions from physical, occupational and speech therapists in order address the multiple impairments as a result of the stroke. In order to provide comprehensive, patient-centered care throughout the continuum of care so the patient can maximize his/her function, a team approach is vital. If limits are set on the number of visits, the patient may not receive needed services that are important for recovery and the condition can worsen, thereby resulting in increased health care costs in treating a more complex and serious condition.

It is crucial to enhancing both access to and quality of care that the provision of these essential services not be limited by arbitrary restrictions on the number of annual visits as this could result in insufficient and ineffective treatment for the condition, thus exacerbating the condition and resulting in substantially increased costs to the health care system and the individual through increased hospital readmissions and frequent visits to the emergency department. This scenario is what the Affordable Care Act attempts to prevent, or at least mitigate by including a provision stating that no annual limits or lifetime limits may be set on essential health benefits. Arbitrarily allowing restrictions on the number of visits runs counter to best practice standards. For example, some standard option private health plans would be insufficient for the adequate number of physical therapy visits needed to treat many individuals with stroke and those who may have sustained a head trauma, who often require visits which exceed an arbitrary number of

visits limit – such as 50 or 75 annual visits of combined physical therapy, speech and occupational therapy. Clinical appropriateness should guide the treatment plan rather than an arbitrary limit of visits or cap.

Finally, section 1302(b) of the Affordable Care Act’s rehabilitative services essential health benefit designation also includes devices related to physical therapy treatment. Physical therapists are often involved in fitting patients with orthotics, prosthetics, or the appropriate wheelchair or other medical devices during therapy treatment to facilitate function. It is crucial that this equipment is a covered benefit and that essential benefits are defined to explicitly provide that all durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) are included in the meaning of “devices” as essential medical benefits in relation to devices physical therapists utilize in providing health services.

“Medical Necessity”

Insurers define medical necessity in non-uniform ways. Definitions of “medical necessity” point to accepted standards of good health care practices, then can further define the term as being curative or rehabilitative, or “clinically appropriate.” Definitions additionally stipulate that treatment cannot be solely for the patient’s convenience.

APTA believes that health care practitioners should determine what method, scope or type of treatment is medically necessary. APTA supports a definition that does not restrict the patient from access to the appropriate qualified health care provider and the appropriate care setting. We support a definition that leaves the number of visits necessary for the medical treatment to the discretion of the health care provider to ensure both appropriate and increased quality of care based on standards of good practice. Additionally, a patient’s continued treatment should not be jeopardized by the imposition of increasing co-payments or premiums if the number of visits under standards of good practice conflict with the arbitrary limits in the insurance policy.

Medical necessity can also mean different things to different stakeholders. Individuals with disabilities have different requirements to acquire services and equipment that is medically necessary versus a patient with an acute therapeutic medical condition. Medical necessity should be defined with recognition for the varying populations that receive short and long term rehabilitative care. CMS Ruling 95-1 provides guidance of what criteria and methods should be used to determine medical necessity in determining the existence of “acceptable standards of practice” for Medicare contractors, within the local medical community. The following criteria should be considered: reliance on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. “Published medical literature” refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the *New England Journal of Medicine* and the *Journal of the American Medical Association*. A consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross

Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine. *See also Medicare Claims Processing Manual*, CMS Pub. 100-4, Ch. 30, § 40.1.3.

Using organizational policies or rules of thumb to determine medical necessity can have detrimental effects on quality of care and potentially violate constitutional law. The courts have recognized the need to tailor health care delivery to that patient's unique health concerns, particularly individuals with disabilities who have unique health care needs. Individuals with multiple disabilities that complicate and prolong rehabilitation often require extensive skilled physical therapy. Denial of essential services could be deemed a constitutional law violation. *See Fox v. Bowen*, 656 F. Supp. 1236 (D. Conn. 1986) (Fiscal intermediaries that routinely deny Medicare claims for skilled physical therapy on the basis of "informal presumptions or rules of thumb" violate an individual's due process rights).

It will be important to ensure that all levels of evidence are included in decisions regarding coverage, particularly when a "gold standard" of evidence is not available. These levels of evidence include, but are not limited to, case studies, clinical guidelines, and clinical decision-making.

Allow Latitude for Treatment Variations While Balancing Costs

Under the Affordable Care Act, the Secretary is directed to "[n]ot make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life" and also to "[e]nsure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life." These requirements direct the Secretary on factors for not excluding benefits.

APTA urges the Agency to ensure that the details of the benefits packages meet the requirements specified in the Affordable Care Act. The essential benefits packages should also provide the services necessary to cover individuals with disabilities, low-income and age-specific conditions. The difficulties experienced by these populations are great due to the difficulty of accessing medical care. The essential benefits established for these groups should provide a broad array of options for the practitioner to select from to allow for the appropriate yet most fiscally responsible choice of care. Restricting the options of treatments by defining the benefits too narrowly could result in increased costs to the health care system due to exacerbations of conditions. For example, an individual with multiple co-morbidities such as diabetes, coronary artery disease, and chronic obstructive pulmonary disease (COPD) who had a stroke will require extensive interdisciplinary care, including physical therapy, in order to safely return the individual to his/her home. If only 20 physical therapy visits are allowed per year, this could easily be exhausted before functional goals are close to being achieved.. In addition, the individual may require speech services for swallowing which will also decrease the

number of physical therapy visits that can be covered by insurance. It is unlikely that this individual will be able to afford to pay for these services out of pocket. Therefore, this individual will most likely be limited to a wheelchair or bed. With the existing comorbidity of diabetes, pressure ulcers could result leading to infection. In addition, because of the immobility and the person's history of COPD, the risk of pneumonia increases substantially.

Another example could involve an individual who has experienced a traumatic brain injury (TBI): a 20 year old man is a victim of a robbery with resultant beating and sustained a brain injury resulting in a loss of consciousness of greater than 6 hours. He was hospitalized for 4 days then transferred to an Inpatient Rehabilitation Facility where he received physical, occupational and speech therapy 3 hours each day. After 14 days, he was discharged to his parent's home in a wheelchair with deficits in the area of cognition (decreased attention, increased distractibility, and poor memory); difficulty speaking and being understood (expressive aphasia); decreased balance; ataxic gait; increased tone in the upper and lower extremities, limitations in activities of daily living and mobility. He required home care services consisting of physical therapy to increase and progress his dynamic balance and mobility from the wheelchair to ambulation with a walker with minimal assistance, occupational therapy to increase his independence in activities of daily living (ADL), and speech therapy to improve his expressive speech. Vocational rehabilitation is also involved to determine his abilities and skills to facilitate employment. He was previously employed as a cook in a fast food restaurant. If this man did not receive adequate rehabilitative services, he would be confined to a wheelchair which could result in multiple problems such as, increased risk for pressure ulcers, increased risk of pulmonary complications, and obesity. He would likely not be employed and may need several visits to the emergency department for various infections and other complications.

Additionally, latitude for treatment must be provided due to variations in treatment for children versus adults. For example, a 9-year-old girl sustained a motor and sensory complete C7 spinal cord injury (SCI) after a motor vehicle accident at age 5 (American Spinal Injury Association [ASIA] impairment classification A). She received surgery with rod fixation to correct a paralytic spine deformity. A right hip dislocation with shallow acetabulum was revealed on radiographic examination. Before surgery the child was independent in transfers to and from her wheelchair, dressing her upper and lower body, performing bed mobility skills such as rolling, assuming a sitting position from supine; however, since the surgery she requires moderate assistance. The parents' goal is for the child to return to her pre-surgery functional level. At home she requires physical therapy for transfer training to and from the wheelchair, increased bed mobility, seating modifications to keep the acetabular head in place, upper extremity strengthening to facilitate transfer training and sacral pressure relief, and household modifications to decrease barriers. She also requires occupational therapy for ADL training, including dressing and toileting. Once she is able to return to school, she will require continued therapy within the school environment. If this child is unable to receive services, she would require constant care by her parents or others, additional services to provide education, and negative health sequelae could result, such as pressure ulcers, additional

hip dislocations causing pain and deformity, lack of lower extremity range of motion due to unchecked spasticity causing difficulty in mobility, toileting, dressing, and bathing. All of these additional requirements and complications have long term ramifications, including increased costs and burdens on the individual, the family and the health care system and a reduction of quality of life.

APTA believes imposing numeric limits on essential benefits is inappropriate given the provisions included in the Affordable Health Care Act that prohibits annual or lifetime limits on essential benefits. However, we recognize that unlimited treatment that is of no value is not appropriate. Medical necessity and effectiveness of care are important principles to keep in mind. Where documented treatment guidelines exist, these may be appropriate to use (e.g., Official Disability Guidelines, Presley Reed); however, these guidelines must be balanced with processes that allow health providers to vary from the guidelines where it is medically appropriate and on a case-by-case basis. The process should neither delay the provision of care, nor be overly burdensome to providers or patients.

Actuarial data should be utilized if certain limits are allowable. In establishing the minimum requirements for the actuarial value and level of benefits coverage, particular consideration should be paid to the composition of the risk pool including the number of covered lives and beneficiary characteristics such as age and occupation. Unique criteria of local and state populations should be accounted for. Some states have very specific beneficiary populations that will need special consideration when establishing limitations criteria. For example, many states (e.g. Mississippi, Texas) have high obesity rates. Obese patients typically suffer from multiple co-morbidities such as diabetes which can be expensive and have significant detrimental effects on patient health and overall quality of life. Other states are dominated by what might be considered high risk occupations such as coal mining or farming in which health care costs might be higher due to injury or long term co-morbidities associated with such occupations. These characteristics have a significant impact on the ability to appropriately risk adjust the pool of covered lives.

Allowing benefits packages to vary based on actuarial equivalence is important to ensure that any package can evolve naturally based upon the uniqueness of the community, as well as new innovations in new technology, the most recent clinical evidence and innovations in benefit design.

It has been suggested that the health care reform essential health benefits be modeled after the Federal Employee Health Benefit Model of Blue Cross/Blue Shield's basic option. However, the package of services provided under this plan are inadequate in many areas affecting women, children and individuals with disabilities, including, but not limited to, no coverage for children for many forms of physical, speech and related therapies, and a lack of coverage for many forms of durable medical equipment (DME) needed by individuals with chronic diseases such as cerebral palsy. Physical therapists are often involved in fitting patients with orthotics or the appropriate wheelchair during therapy treatment. In treating individuals who are disabled or require medical equipment, it is crucial that this equipment is included as a covered benefit and that essential benefits

are defined to explicitly provide that all DMEPOS are included in the meaning of “devices” as essential medical benefits in relation to devices physical therapists utilize in providing health services.

Several laws exist at the federal level which could be utilized to ensure that the benefits provided are easily accessible and that the policies do not discriminate against potential plan participants. These include the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

Individual and Community Education and Consumer Choice

Additionally, APTA does not believe the intent of the regulations is to attempt to balance treatment among all of the defined categories because every service is not needed for every patient, yet many services are offered routinely in conjunction with another, for example, chronic disease management and rehabilitative services. Instead, the practitioner should be provided a menu of options to choose from to treat a patient in the most medically appropriate way. Denial of benefits on the basis of age, expected length of life, present or predicted disability, degree of medical dependency or quality of life should be prohibited. Essential benefits for these individuals should be determined on the basis of enhancing quality of life and condition rather than applying standard condition improvement measures. These individuals traditionally experience financial hurdles which have resulted in delayed or substandard medical care. It is sound public policy to include mechanisms to educate individuals on the changes to and availability of the health care system as a result of PPACA. The impact of community education can be significant and deter negative and costly health consequences.

Further, reduction of health care barriers and allowing individuals the opportunity to choose their primary care provider, obstetrician-gynecologist, and physical therapist, further empowers individuals in the disease management process by providing them adequate choice and control over the available providers. All insurers should be rated on the same criteria to ensure fairness in the comparisons between plans, and consumers should also have access to customer satisfaction ratings.

Flexibility

As demonstrated through implementation processes for other federal initiatives, providing flexibility to states which allows them to establish additional standards above and beyond federal standards creates an environment where confusion can flourish. Insurers operating in multiple states could incorrectly assume that a requirement of one state is applicable to all states in which they operate. If a great degree of latitude is afforded to the states, appropriate education should be provided to ensure all stakeholders are aware of the minimum federal requirements and how to obtain information regarding any additional state requirements. However, flexibility allows for innovation at the state level which could enable “best practices” that can be used by other states to improve the development of their Exchange.

When developing Exchanges for states who elect not to or are unable to establish an Exchange the federal government will have to work closely with the state to ensure that rules for those plans within the Exchange do not conflict with rules established by the states for the plans operating outside the Exchange. Many stakeholders have expressed concern that if the rules are different or incongruous for plans inside and outside of the Exchange that it could lead to adverse selection. In this instance, plans within the Exchange might be filled with high-risk, high-cost patients increasing the cost for those plan participants and in some ways undermining the intent of the Exchanges.

Note that many states are currently experiencing significant economic hardships due to the economic downturn of the last few years. Various federal initiatives, such as incentive payments for meaningful use of electronic health records, expansion of the Medicaid benefit to 133% of the federal poverty level, and transition from ICD-9 to ICD-10 will add to the strain on state budgets and administrative infrastructure despite federal financial assistance. The economic health of a state could have significant implications for the development of an Exchange at the state level. Planning grants and technical assistance could mitigate the impact of this additional financial strain.

States will need to determine what administrative infrastructure is currently in place. If the state has a robust administrative infrastructure that is well-staffed, the resource needs related to the development of an Exchange will not be as great as those states with a limited infrastructure. If a state needs to turn to a third party to administer its Exchange, it could minimize the administrative burden but could prove costly.

If a state is able to effectively facilitate enrollment into and/or between various social service programs such as the Exchanges, the Children Health Insurance Program (CHIP) and Medicaid, the need to design such systems in the future (and the cost associated with their design) will be minimized. If the state does not have the ability to streamline these enrollment processes it will likely need a greater degree of financial and technical assistance than its counterparts to develop this capability.

Finally, if a state develops an Exchange that fails to gain the support of key stakeholders such as the insurance plans or health care providers, appropriate risk adjustment cannot exist and states may find the Exchange is comprised of chronically ill or other patients considered “high risk” by insurers. This could preclude the Exchange from meeting its intended goal of making insurance affordable as well as easy to select and purchase. Failure to attract the appropriate number of health care providers could also jeopardize the sustainability of the Exchange. This could limit the ability of the Exchanges to expand health care coverage to a greater number of Americans, reduce health care costs, and improve overall public health. Some states may need some form of technical assistance to help avoid such pitfalls.

Plan Rating System

The Medicare program has undertaken the development of plan rating systems for various practice settings such as their home health, nursing home, and hospital compare

programs that CMS could use as a model as it develops a plan rating system for the Exchanges. These programs enable a beneficiary or his or her caregiver to use a web-based portal to assess quality on a variety of factors including cost, location, consumer satisfaction, and performance of various quality actions. Regardless of what plan rating system is ultimately adopted it, should be comprehensive (e.g. take into consideration cost, plan offering, adequacy of provider network) to ensure that consumers have all the information necessary to determine what plan is best for them. Additionally, all insurers should be rated on the same criteria to ensure fairness in the comparisons between plans. Consumers should also have access to customer satisfaction ratings. This system could be further utilized for periodic review and updating of essential packages. Transparency across a variety of levels will be crucial in ensuring consumers understand the quality and cost of their plan choices. Consumers will need to be able to compare and contrast plans based on factors such as covered benefits, cost, provider networks, and quality. Consumers should also have a clear understanding of their rights under the health plan including their appeal rights.

Quality improvement programs which include quality measures are an important mechanism to ensure appropriate and timely care are provided to patients and to track the effectiveness of new treatments and scientific developments. However, several factors should be considered when developing any quality measurement program insurers will be required to utilize as a participant of the Exchange. First, quality measures should be developed for a wide variety of health care providers including physical therapists. Developing measures for a wide variety of health care providers has the potential to improve care coordination among these providers and ensure that various health care conditions are targeted for quality improvement. These measures should also address a variety of conditions, including chronic conditions. Quality measures that target chronic conditions, which are often expensive and exact a high toll on the quality of life of patients, are a crucial mechanism to reduce cost and improve individual and population health. Second, participation in quality improvement initiatives should minimize the burden on health care providers. Many quality reporting initiatives currently underway allow providers to indicate their participation or that a quality action was performed via a claim form, a registry, or electronic health record. The types of quality measures developed typically can be reported in a way that does not require chart abstraction or submission of documentation, processes which can be administratively burdensome and expensive.

Third, different types of quality measures including structural, process, and outcomes measures that are appropriately risk adjusted should be developed. Process measures, often based on evidence-based practice, facilitate the adoption of best care practices by a larger number of health care providers. Outcomes measures, which allow health care providers to demonstrate the results of their care, should receive special consideration. One challenge outcomes measures present is the possibility of penalizing a provider who delivered quality of care but still had negative health outcomes due to factors outside of the provider's control, such as patient non-compliance with health care instructions. Allowing health care providers a range of options to demonstrate the quality of the care they deliver via different forms of quality measures, will improve patient health, and

ensure providers are not inappropriately penalized for patient health outcomes beyond their control.

A mechanism for policy input by stakeholders at the state and federal levels should be implemented. A public-private advisory group should be created which recognizes the stakeholders with relevant policy expertise. An individual from each provider group should be in the group, including, a physical therapist. The core mission of the advisory group could be identifying changes in public priorities identified through public input and/or policy changes at the state or national level for updating essential packages.

State Mandates

Currently, states do not have substantial direct cost from adding a substantive health insurance mandate; any increased costs are passed on to the insured population in the form of premium increases. States may face increased premium costs for their own employees as a result of the mandate, but the cost is often not significant. Once PPACA becomes effective, states will face the full cost of the premium increase for any resident that qualifies for the premium tax credit. States have to calculate that the benefit associated with the mandate outweighs its real cost. The expected result is that fewer mandates are likely to come through at the state level and states may repeal existing mandates that end up exceeding the requirements of federal essential health benefits.

The inclusion of current state mandates under essential health benefits would mitigate this expense. However, the lack of uniformity among state mandated health benefits among the states could result in difficulty in implementation. States are free to continue mandating benefits for policies sold outside of the exchange without facing any direct cost. One outcome may be that states will change all of their existing mandates to apply only to non-exchange policies and ensure that any future mandates are similarly restricted. However, if a state's non exchange-based policies have greater coverage requirements than exchange-based policies, there is a possibility that the non-exchange-based policies will suffer due to adverse selection.

Conclusion

In conclusion, it is vitally important that individuals, especially vulnerable populations such as children, the disabled and at-risk adults, are able to access care that is medically necessary for their health condition. The inability to obtain care or receive appropriate care results in a substantial cost to beneficiaries, states and the health care delivery system as a whole. The intent of the Exchanges is to make services available and affordable to populations who have been excluded under prior law.

APTA commends the HHS on allowing stakeholders the opportunity to comment on this important regulation which will allow states to increase access to services, improve care delivery and health outcomes to the consumer, and improve cost efficiencies. We strongly urge HHS to encourage states to align benefits between Medicaid and the Exchanges to reduce costs and administrative burdens. Additionally, data collection and

monitoring activities by states will result in more valuable data to measure care outcomes and further reduce administrative burdens in the Exchanges. Decreasing costs while allowing access to quality health services has been evidenced by innovative payment models such as medical and health homes and other integrated service models. These efforts will require increased participation and collaboration with all stakeholders.

APTA looks forward to working with HHS in its efforts to establish a flexible definition of rehabilitative services as an essential health benefit. Thank you for your consideration of our comments. If you have any questions regarding our comments, please contact Deborah Crandall, Associate Director of Payment, Policy and Regulatory Affairs, at 703-706-3177 or deborahcrandall@apta.org.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Scott Ward". The signature is stylized and cursive, with a large initial "R" and "W".

R. Scott Ward, PT, PhD
President