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Submitted Electronically

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Ms. Marilyn Tavenner
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Room445-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
ATTN: CMS-2334-P

RE: The American Physical Therapy Association's Response to the Proposed Rule: *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing*

Dear Ms. Tavenner:

On behalf of our 84,000 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 Centers for Medicare and Medicaid Services (CMS) in response to the proposed rule, *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing*, released on or around January 22, 2013. We respectfully provide the following comments:

Rehabilitative Services (§ 440.347)

Physical therapy services encompass the diagnosis of, interventions for, and prevention of impairments, activity limitations, and participation restrictions related to movement, function and health. (*Interactive Guide to Physical Therapist Practice by American Physical Therapy Association*. 2003. ISBN: 978-1-887759-87-8. DOI : 10.2522/ptguide.978-1-931369-64-0) Physical therapists are licensed health care professionals who diagnose and manage

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movement dysfunction and enhance physical and functional status in all age populations. Physical therapists are qualified to provide rehabilitative and habilitative services, defined categories of essential health benefits by the Secretary of the Department of Health and Human Services (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 CMS 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. Rehabilitative services are an optional outpatient benefit under the traditional Medicaid program. We are pleased that the mandatory essential health benefits, including rehabilitative and habilitative services, will be offered to the newly eligible population in states that choose Medicaid expansion.

APTA believes the inclusion of essential health benefits such as rehabilitation under Medicaid expansion provides states with a cost effective non-surgical intervention that can be provided across all settings to avoid costly hospitalizations. We support 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, particularly with the Medicaid population who has not had ready access to medically needed services.

A physical therapist must assess patient goals, preexisting conditions, and co-morbidities in order to provide patients with a valid, nonsurgical option that can restore and improve motion. *The Low Back Treatment Guidelines* published in the *Journal of Orthopedic and Sports Physical Therapy* illustrate such an approach. Also noteworthy is a 2012 study published in the scientific journal *Spine* showing that early access to physical therapy by patients with low back pain improved patient outcomes and decreased health costs. Other studies have shown that physical therapy can be a cost-effective alternative to long-term use of prescription drugs or surgery. For instance, a 2012 study, also appearing in *Spine* showed that patients who received physical therapy soon (within 30 days) after an episode of acute low back pain had a lower risk of subsequent medical service usage (surgery or epidural steroid injections) than did patients who received physical therapy after a longer period of time had elapsed. In addition, a 2010 study in the *Journal of the American Medical Association* (JAMA) highlights the rise of complex and risky spinal fusion surgeries among Medicare patients with simple spinal stenosis, confirming the need to look at alternative methods of treatment such as physical therapy.

In this current environment of practitioner shortages, it is imperative that vulnerable populations, such as those transitioning between Medicaid and the Affordable Health Insurance Exchanges ("Exchanges") be able to access the appropriate health care services - including physical therapy - and practitioners that they medically require. We commend the Secretary on allowing states' flexibility in both defining habilitative services and selecting benchmark Medicaid Alternative Benefit Plans (ABPs) and EHB

benchmark plans to meet the unique needs of each state's population. Additionally, this flexible approach issuer innovation in benefit design development. We also realize that these services must be delivered within fiscally responsible constraints to control health care expenditures. APTA is concerned about offering the habilitative benefit in parity with the rehabilitative benefit. We also remain concerned about the proposal that allows plan issuers to substitute benefits within categories as referenced in the *Patient Protection and Affordable Care Act; Standards related to Essential Health Benefits, Actuarial Value, and Accreditation* proposed rule and the February 17, 2012, HHS bulletin, *Frequently Asked Question on Essential Health Benefits Bulletin*, after establishing actuarial equivalence, among other requirements, prior to offering the plan on the Exchange. To expand upon these concerns, please consider the following:

Rehabilitative Benefits' Flexibility (§ 440.347)

Under section 1302(b) of the Patient Protection and Affordable Care Act (ACA), 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 impairments, activity limitations, participation restrictions, and environmental barriers 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, activity limitations and participation restrictions 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. Moreover, 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 requirements that could potentially impede access to rehabilitative services deemed essential under the ACA.

Additionally, plans should not be developed -with "rules of thumb" policy that limit the provision of rehabilitative services in health plans. The determination of which

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, such as requiring parity between rehabilitative and habilitative services, could impinge upon the patient's ability to receive comprehensive, quality care for their condition.

Benefit Substitution (§ 440.347(d))

Similar to requiring parity, allowing benefit substitution could result in an individual choosing a plan that does not meet their medical needs. The provider should have the ability to determine which service is medically necessary and the authority to make the benefit substitution as the practitioner deems appropriate. This substitution should not occur when a plan is issued, leaving both the practitioner and patient in need of one benefit, but having no access to it. After the release of the HHS February 17, 2012, bulletin, allowing for substitution of rehabilitative and habilitative benefit, APTA's interpretation was that plan issuers could offer a plan that would allow free substitution within the plan based on patient need. For example, a plan could offer 30 annual visits of either rehabilitative and/or habilitative services. The number and type of these services would then be determined by the provider as medically necessary.

However, the November 20, 2012 *Patient Protection and Affordable Care Act; Standards related to Essential Health Benefits, Actuarial Value, and Accreditation* proposed rule implied that the issuer would create a substituted benefit plan (which would have to be approved), then offer it on the Exchange. This approach could leave a provider no choice - or a limited choice - in providing a medically necessary service. This is a concern as one plan that substituted habilitative services for rehabilitative services and was deemed actuarially equivalent, could then be chosen by a patient who subsequently experiences a condition in which rehabilitative services are crucial, such as a stroke. Under this plan, the patient would have no rehabilitative benefit. Similarly, an individual with autism who may require a more robust habilitative benefit, may select a plan with rehabilitative services. Even envisioning that a plan issuer could offer multiple plans on the Exchange (e.g., one plan that offers only habilitative benefits and one that offers only rehabilitative benefits), a patient could inadvertently choose a plan not realizing the benefit discrepancy, or choose one that would not meet his or her needs as a result of an unforeseen illness, injury or condition that occurs that year.

"Parity" (§ 440.347(d))

Similarly, requiring parity¹ between rehabilitative and habilitative benefits could be problematic. Treatment limitations should not be more restrictive for one benefit than

¹ "(1) Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services" *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing* 78 Fed. Reg. 14 (proposed Jan. 22, 2013)(to be codified at 42 C.F.R. pt. 156).

another, however, that should mean that similar treatment should be provided in similar amounts and durations as medically necessary for the patient. For example, if a state APB must offer the same amount of rehabilitative service visits as habilitative services to be considered in “parity,” this could result in a patient being impeded from receiving the medically necessary service.

Habilitation services are commonly known as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. In most cases, habilitation services also encompass administrative and transportation costs. Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) addresses these services specifically. Habilitative services complement rehabilitative services and are integral to ensuring that the patient receives comprehensive care that restores him/her to maximum functional levels. Therefore, both substitution among and parity between these services could be problematic if the patient’s medical condition requires significantly more rehabilitative services than habilitative services and vice versa.

Additionally, APTA advises caution in restricting the number of therapy visits in essential health benefits plans (whether through parity or arbitrary visit limits) without allowing for an exceptions process for several reasons. This is particularly advisable if complete and/or partial substitution of benefits will be allowed within the rehabilitation/habilitation services category. In most insurance plans, the number of physical therapy visits allowable per year is 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 to 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 complete substitution of benefits is allowed or visits are decreased, the patient may not receive needed services that are important for recovery and the condition can worsen. This can result in increased health care costs in treating a more complex and serious condition.

It is crucial to enhancing access to and quality of care that the provision of these essential services not be eliminated or limited by arbitrary restrictions on the number of annual visits. The Affordable Care Act seeks to prevent such issues mandating no annual or lifetime limits may be set on essential health benefits. Arbitrarily allowing restrictions on the number of visits or eliminating a benefit – such as rehabilitative services – as an option runs counter to this mandate. For example, some standard option private health plans would be insufficient for the appropriate number of physical therapy visits needed to treat many individuals with stroke and those who may have sustained a head trauma. Clinical appropriateness should guide the treatment plan rather than curtailing or eliminating visits.

Additionally, section 1302(b) of the Affordable Care Act's rehabilitative services essential health benefit designation 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. Benefit substitution for DMEPOS could also be problematic and costly for consumers, health care providers and, ultimately, states.

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 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 most appropriate choice of care. Restricting the options of treatments by allowing complete or partial substitution within categories with no option for a health care provider to choose whether rehabilitative services or habilitative services is most appropriate for a particular patient (because of its preclusion or limitation through the parity process) 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 the patient chose a plan where the addition of habilitative services benefits limited physical therapy visits to 10 per year, this could easily be exhausted before functional goals are 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. Often patients cannot 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 co-morbidity 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. In this example, this individual's quality of life would be substantially impacted and his or her life span potentially shortened.

The choice of a plan with limited rehabilitative services benefits due to substitution could also impact care as a result of unforeseen circumstances. Consider another example which involves 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 patient 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.

The patient is 5 years old with developmental delay as a result of excessive maternal alcohol consumption during pregnancy. The child experienced prenatal and postnatal growth retardation, including microcephaly and CNS dysfunction, including mild-to-moderate mental retardation, delay in motor development, hyperactivity, and attention deficit. The patient is receiving habilitation services including physical therapy for neurodevelopmental facilitation and proprioceptive stimulation, progression of exercises to facilitate development of muscle tone, strength, and balance; and mobility/motor skills

including handling techniques to facilitate progressive stepping movements; occupational therapy for sensory integration and fine motor coordination; and speech therapy for oral/pharyngeal activities to facilitate swallowing and communication. The patient will require extensive services to learn skills that will bring him closer to an age appropriate developmental level allowing him to function in a school environment and at home. If the patient does not receive services, the patient will be at risk for major complicating health conditions such as aspiration pneumonia, musculoskeletal deformities, skin breakdown and may require state institutional care or, if the patient remains at home, frequent trips to the hospital emergency department which will be costly.

APTA maintains that 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 and that states are under serious budget constraints. 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. Allowing substitution of benefits further complicates the process of providing appropriate and necessary services.

Allowing benefits packages to vary based on actuarial equivalence is important to ensure that packages can evolve naturally based upon the uniqueness of the community, as well as new innovations in technology, the most recent clinical evidence and developments in benefit design. However, complete or partial benefit substitution that decreases visit limits within one category runs counter to a state's ability to provide health plans that serve its unique population characteristics and limits a practitioner's ability to provide medically necessary care.

Resolving Conflict between Substitution and Discrimination (§ 440.347(e))

Under the Affordable Care Act, §156.125(a), 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 non-exclusion of benefits. Again, we are concerned that a patient could choose a substituted-benefit approved Medicaid health plan that does not offer the medically necessary services.

Individuals with disabilities have different requirements to acquire services and equipment that is medically necessary versus a patient with an acute therapeutic medical

condition. Elimination of a benefit within a benefit category could leave a patient without – or with very limited - medically necessary services. Medical necessity should be defined with recognition for the varying populations that receive short and long term rehabilitative care. Health plans offered to patients either under Medicaid or through the Exchanges may be discriminatory if medically necessary services are not offered. 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. Using organizational policies or rules of thumb to determine medical necessity can have detrimental effects on quality of care and potentially violate constitutional law. 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). Allowing substitution of one type of essential health benefit to the preclusion of another essential health benefit could equate to a denial of medically necessary services.

APTA remains concerned, however, about the timeline for remediation of discovered discriminatory practices since the framework for such analysis is under the development process and the responsibility of each state. We urge HHS to develop an analysis tool which states can utilize to identify discriminatory practices and to expedite remediation.

Public Notice (§ 440.386)

We commend CMS on ensuring that public notice is timely provided for any establishment or amendment to an ABP. However, if the revision involves providing coverage that is less than the state’s approved state plan we would request that public notice take place sooner than 2 weeks prior to submission of the state plan amendment. An amendment that reduces coverage could adversely impact providers and patients. Additionally, providers would need adequate time to provide input and ensure they are in compliance with a reduced benefit plan.

Conclusion

In conclusion, it is vitally important that individuals, especially vulnerable populations such as children, the disabled, low income 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 EHB requirement for the newly eligible adult population under the Medicaid program and in the Exchanges is to make services available and affordable to populations who have been excluded under prior law.

APTA commends CMS on allowing stakeholders the opportunity to comment on this important regulation which will allow states to increase access to services, and improve care delivery and health outcomes to the consumer. We reviewed the November 20,

2012, State Medicaid Director letter and strongly urge CMS 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 and between state Medicaid programs and the Exchanges. These efforts will require increased participation and collaboration with all stakeholders.

APTA looks forward to working with CMS in its efforts to ensure that appropriate physical therapy services are available as an essential health benefit to patients. Thank you for your consideration of our comments. If you have any questions, please contact Deborah Crandall, J.D., Senior Regulatory Affairs Specialist, at 703-706-3177 or deborahcrandall@apta.org.

Sincerely,

A handwritten signature in black ink that reads "Paul Rockar Jr." in a cursive script.

Paul Rockar, Jr. PT, DPT, MS
President

PR/dc