November 17, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
CMS-9930-P
200 Independence Avenue, SW
Washington, DC 20201.

Submitted Electronically

Re: CMS-9930-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments in response to the Centers for Medicare and Medicaid Services’ (CMS) Calendar Year (CY) Notice of Benefit and Payment Parameters proposed rule. The mission of APTA is to further the profession’s role in the prevention, diagnosis, and treatment of movement dysfunctions and enhancement of the physical health and functional abilities of members of the public. Physical therapists are highly educated and trained professionals who provide services across the care continuum ranging from wellness and prevention to rendering treatment in a variety of settings. Therapists perform evaluations that include a patient history, review of systems, and administration of standardized tests and objective measures based on the patient’s presentation and clinical findings.

Through a collaborative process with the patient, family, and other members of the health care team, the therapist develops goals and a plan of care to address the evaluation findings and specific needs of the patient. The physical therapist executes that plan of care by providing skilled techniques and procedures designed to optimize movement and function. Evidence-adherent physical therapy is an essential component in reducing the risk of adverse events including functional decline, falls, progression of pain or the long-term need for pain medication, avoidable surgical procedures and/or hospitalizations, and disability.
The Affordable Care Act’s (ACA) requirement that individual and small group markets cover essential health benefits (EHBs) in 10 benefit categories ensures that patients have access to basic coverage. APTA strongly supports the preservation of the EHBs, particularly the category of rehabilitative and habilitative services and devices. Conservative rehabilitative services such as physical therapy, which improve a patient’s ability to function, participate in activities of daily living, and maintain productivity, are essential to optimizing health outcomes and reducing overall health care costs. Marketplace enrollees deserve the same access to, and coverage for, services as individuals who are covered by private health plans outside of the Marketplace. It is imperative that insurance plans sold under the ACA exchanges continue to be required to cover EHBs, including physical therapy. APTA strongly urges that CMS maintain the current federal standard to ensure consumers’ continued access to medically necessary rehabilitative and habilitative services and devices.

APTA is committed to advancing the safety and quality of health care, and is eager to work collaboratively with the Department of Health and Human Services (HHS) and the states to promote access to appropriate, value-based services.

As CMS works to implement the policies proposed in this rule, we strongly urge the agency to consider the following recommendations:

Recommendations

- APTA recommends that CMS not modify the SHOP eligibility determination process due to the potential administrative and financial burden it may impose on employers.
- APTA has serious concerns that granting states such wide latitude in setting EHB-benchmark plans will have a devastating impact on patient continuity of care, ongoing patient-provider relationships, and patients’ ability to access medically necessary services. We urge CMS not to modify the current process by which states choose an EHB-benchmark plan.
- To avoid market disruption and consumer confusion, we strongly recommend that CMS not finalize its proposal to permit states to select a new EHB-benchmark plan on an annual basis.
- Should CMS move forward with its proposal to provide states with additional flexibility in how EHB-benchmark plans are selected, APTA strongly recommends that CMS define a typical employer plan as one that covers all 10 EHB categories. Additionally, CMS should require the use of 1 standardized notice and public comment process that all states use when a state proposes to change its EHB-benchmark plan.
- APTA strongly recommends that CMS not codify the proposed changes to the Navigator program. Eliminating such a valued and proven consumer assistance tool will harm enrollee ability to make well-informed coverage and health care decisions.

Eligibility Determination Process for Small Business Health Options Program (SHOP) beginning on or after January 1, 2018

APTA represents physical therapists in private practice who may qualify to purchase coverage within the SHOP. We appreciate that through the policies proposed within the rule CMS is attempting to reduce the barriers encountered by employers when attempting to
obtain SHOP coverage for their employees. However, we disagree with several of CMS’s proposals, as detailed below.

CMS proposes that SHOPs take responsibility for determining employer eligibility for coverage. However, the SHOPs would not always need to do so prior to the issuer allowing the purchase of coverage in a qualified health plan (QHP). Hence, an employer could purchase a QHP before obtaining a determination of SHOP eligibility. CMS would require the SHOP to notify employers not only of a denial of the employer’s eligibility but also of termination of eligibility.

APTA has concerns that these proposals could impose an unnecessary burden on employers seeking coverage. If SHOPs no longer are required to notify an employer of eligibility in advance of the purchase of a QHP, employers that purchase a QHP but are subsequently found ineligible—possibly in error—must undertake an arduous campaign to appeal the decision. Alternatively, if eligibility cannot be verified, coverage would be terminated, and employees would commence the process of enrolling in a health plan during the special enrollment period. We request that CMS provide clarification within the final rule on why the agency deems it necessary to revise the eligibility determination process as proposed.

Moreover, we urge CMS to assess the onerous administrative processes that an employer must follow if subjected to an eligibility review. The employer must offer evidence to support the application for SHOP eligibility within 30 days from the date of notice of the eligibility review. The 30-day turnaround is overly burdensome for private practices with limited resources. To enhance flexibility and reduce burden, we strongly recommend that CMS provide employer SHOP applicants a 90-day period to provide additional required documentation to verify eligibility.

In summary, APTA encourages CMS to maintain the current eligibility determination process and extend the length of time during which employers are required to respond to eligibility reviews.

**Flexibility for States to Update Their EHB-Benchmark Plans**

CMS has proposed that a state may select a new EHB-benchmark plan on an annual basis. CMS also proposed giving states additional latitude and more options as to how the EHB-benchmark plan is selected. Instead of being limited to the current 10 options, states would also be allowed to:

1. Select the EHB-benchmark plan that another state used for the 2017 plan year;
2. Replace 1 or more EHB categories of benefits from the state’s 2017 plan year EHB benchmark plan with the same categories of benefits from another state’s 2017 plan year EHB-benchmark plan; or
3. Select a set of benefits to become the state’s EHB-benchmark plan, provided that the plan does not exceed the generosity of the most generous among a set of comparison plans, including the state’s EHB benchmark plan used for the 2017 plan year and any
of the state’s base benchmark plan options for the 2017 year. This plan must also be equal in scope of benefits to what is provided under a typical employer plan.

APTA has significant concerns that the CMS proposal to offer states expanded options in the selection of a benchmark plan and allowing changes on an annual basis will have a detrimental impact on consumers. By CMS’s own admission, consumers with special health needs may be adversely impacted by the proposed rule. Depending on the EHB-benchmark plan selected by the state in which a consumer resides, that consumer may end up with a less-comprehensive plan, resulting in loss of coverage for medically necessary services, interruptions in care, and lack of continuity in provider relationships.

While we believe that CMS should afford a state flexibility in expanding benefits under its EHB-benchmark plan, affording states flexibility to limit benefits will place many patients at risk of losing access to medically necessary benefits within the EHB categories that were previously covered. Physical therapy services are furnished in a variety of settings, including hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, private practices, and physician offices. Determination of the appropriate health care setting is dependent on the acuity, severity, and intensity of impairments. Given the broad spectrum of patients treated by physical therapists, maintaining access to high-quality providers across the care continuum should be a primary consideration.

While the ACA explicitly requires coverage of rehabilitative services, APTA has significant concerns that the CMS proposal will result in limited access to medically necessary care and higher downstream costs. We strongly recommend that CMS not adopt its proposal to provide states greater latitude in the selection of an EHB-benchmark plan, particularly the agency’s proposal to provide authority to states to develop their own EHB-benchmark plan.

Allowing States to Update Their Benchmark Plans Annually
APTA strongly disagrees with the CMS proposal to allow states to select a new EHB-benchmark plan on an annual basis. Such a proposal would impose a significant financial and administrative burden on consumers, health care providers, employers, and plan issuers by requiring them to understand and maintain compliance with repeatedly revised EHBs covered by the plans. CMS’s proposal also would cause significant market disruption and mass confusion, as updating a benchmark plan each year will require each health insurance issuer to update its plan offerings. In turn, consumers, who already encounter enormous difficulty when selecting a plan, will face ever-changing benefits and costs, leading to more consumers selecting plans that do not meet their health care or financial needs. Annual adjustment in the EHBs in conjunction with the proposed reductions to the Navigator program will exacerbate consumer confusion and error in plan selection.

Definition of Typical Employer Plan
The CMS proposed definition of a typical employer plan would facilitate the development of less generous health plans and higher out-of-pocket costs for consumers. Only plans that already cover all 10 EHB categories should be eligible for consideration. APTA strongly recommends that CMS exclude self-insured plans from the definition of a typical employer
plan, as self-insured plans are exempt from state insurance laws that include state-mandated benefits, reserve requirements, premium taxes, etc.

It is imperative that the selection of a new EHB-benchmark plan be done in a transparent, meaningful manner that ensures that consumers, providers, and employers have confidence in and an understanding of the decision-making process.

**Reasonable Notice and Public Comment Period**

CMS proposes to codify reasonable notice and public comment requirements that would apply any time a state changed its EHB-benchmark plan, but the agency does not otherwise propose a standardized process or specific requirement.

Consumers have the right to be active participants in rulemaking on regulations that may affect them. There must be a standard process for state rulemaking on the selection of EHB-benchmark plans. The submission of public comments will be an essential component in helping each state better understand how the proposed EHB-benchmark plan affects its residents. As such, there must be 1 standardized process to adopt or change an EHB-benchmark plan, rather than 50 different notice and public comment requirements, to ensure that all consumers are afforded the same opportunity to provide feedback.

Attributes of this standardized process should include:

- Posting of the notice on the state’s website
- A comment period of at least 60 days
- Ability to submit comments online, in-person, via mail, or by fax
- Posting of proposal language in consumer friendly terms

**Navigator Program**

CMS proposes to remove the requirement that each exchange have at least 2 Navigator entities and that 1 of these entities be a community and consumer-focused nonprofit group. Additionally, the agency proposes to eliminate the requirement that Navigators maintain a physical presence in the exchange service area to provide in-person outreach and enrollment support.

APTA strongly urges CMS not to move forward with its proposed changes to the Navigator program. The program is a valuable consumer assistance tool that helps individuals make informed decisions regarding coverage and health care. Transparent communications about coverage, expected out-of-pocket expenses, availability of subsidies based on financial status, and quality ratings serve as a means to achieving the patient-centered health care that was envisioned in the ACA.

Within the rule, CMS admits that these changes may result in fewer consumer assistance options and potentially no in-person enrollment assistance. APTA contends it is misguided for the agency to drastically reduce the level of assistance. As previously stated, many consumers make mistakes when selecting a plan because they misunderstand the plan’s benefits and costs. Studies have shown that assistance tools and aids improve the likelihood
that consumers will select a cost-efficient health plan. Scaling back the Navigator program will only lead to consumers selecting options that are inappropriate for themselves and their families. We strongly urge the agency to consider the detrimental impact the proposals to modify the Navigator program would have on the most vulnerable consumers.

Rather than stripping away consumer marketplace assistance tools, APTA recommends the agency enhance the breadth and scope of the Navigator program. This would help ensure consumers, and small businesses and their employees have the necessary assistance to adequately review and understand their health coverage options, as well as complete eligibility and enrollment forms. This will be particularly important if CMS moves forward with the proposal to allow states to select a new EHB plan every year.

**Network Adequacy**

CMS proposes to eliminate requirements for state-based exchanges on a federal platform to enforce federally facilitated exchange standards for network adequacy. For 2019 and later, federally facilitated exchanges (FFEs) would rely on state reviews of network adequacy standards, where the states have been determined to have an adequate review process.

We support CMS’s proposal to allow state-based exchanges on a federal platform, like other state-based exchanges, to determine how to implement network adequacy standards in the same manner as stated-based exchanges. However, we seek clarification from the agency on what constitutes an “adequate review process.” Moreover, we question how CMS will ensure that enrollees have timely and geographically accessible care as well as access to sufficiently diverse provider types across all health care settings.

Physical therapists often specialize and receive advanced training in a particular area of practice such as pediatrics, orthopedics, neurology, women’s health, oncology, and cardiopulmonary. Clinical specialization in physical therapy responds to a specific area of patient need and requires knowledge, skill, and experience exceeding that of the physical therapist at entry to the profession and unique to the specialty area. However, therapists offering these services may not be available in all facilities or geographic areas. Preserving consumer access to these highly trained professionals should be given consideration as states render network adequacy determinations.

Additionally, while we support the CMS proposal to better coordinate with states to monitor network adequacy, such as through complaint tracking, we urge CMS to provide further detail on the mechanisms by which it intends to both monitor and enforce network adequacy standards. Enrollees must be able to access providers, such as physical therapists, across the care continuum in all treatment settings. If adequate standards are not in place, states may inappropriately limit physical therapy coverage, resulting in delayed recovery and increased overall health care costs.

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**Conclusion**
APTA appreciates the opportunity to comment on the CY 2019 Notice of Benefit and Payment Parameters proposed rule. We look forward to working with the agency in making revisions to proposed rule prior to its finalization to ensure that access to quality rehabilitation services is preserved. Should you have questions or need additional information, please contact Kara Gainer, Director, Regulatory Affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration.

Sincerely,

\[Signature\]

Sharon L. Dunn, PT, PhD  
Board-Certified Orthopaedic Clinical Specialist  
President

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