



December 21, 2015

Andrew M. Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Attention: CMS-9937-P**

Submitted electronically

On behalf of the over 4200 members of the Private Practice Section (PPS) of the 90,000 member American Physical Therapy Association (APTA), I write to offer comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017” (CMS-9937-P), made public earlier this fall.

Proposed rule CMS-9937-P sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges (FfEs). It also provides additional standards for essential health benefits; cost-sharing requirements; qualified health plans (QHPs); network adequacy; patient safety standards; the Small Business Health Options Program; the definitions of large employer and small employer; and other related topics.

Our comments will focus on network adequacy; cost-sharing requirements; the Small Business Health Options Program; the definitions of large employer and small employer; and certain other related topics.

**NETWORK ADEQUACY STANDARDS**

CMS (or “The Agency”) proposes to standardize a number of policies relating to network adequacy for QHPs on the FfEs. The Agency proposes a quantitative network adequacy threshold to be selected by the State and a Federal default network adequacy standard that would apply otherwise, that is based on the standard currently used for review and several provisions relating to provider transition for QHPs. CMS also discusses a standardized categorization of network depth for QHPs in these Exchanges and their display on HealthCare.gov.

To wit:

Minimum threshold. A QHP in a FFE meets the standard if its network is determined adequate under the following standards:

- (1) In a State that implements an acceptable quantifiable network adequacy metric commonly used in the health insurance industry to measure network adequacy, under that metric; or
- (2) In any other State, under the Federal time and distance standard, based on minimum number of providers and average time and distance to those providers. QHPs that cannot meet the time and distance standard established by HHS may satisfy this requirement by reasonably justifying variances from this standard based on such factors as the availability of providers and variables reflected in local patterns of care.

**PPS COMMENT:** To ensure adequacy of provider networks adopted by QHPs on the FFEs, PPS recommends:

- establishing geographic proximity and waiting time standards that better serve patients;
- ensuring that patients covered in a plan have access to out-of-network providers when the network doesn't offer the specific type of provider a patient needs, or when access can't be provided by the network—all available at no additional cost;
- requiring that health carriers/insurance companies offer monthly updated, accurate provider directories;
- creating an oversight system that allows patients and providers to provide feedback on network adequacy and access.

CMS notes that all QHPs must meet a “reasonable access” network adequacy standard, but FFE plans must meet additional network adequacy standards. It is important to HHS that shoppers at HealthCare.gov do not enroll in plans that fail to meet these minimum standards, so CMS proposes that SBE-FPs that wish to rely on the HealthCare.gov platform require its issuers to meet these same minimum standards. SBE-FPs may exceed these minimum standards. Although the SBE-FPs are legally distinct from FFEs, this difference is not always apparent to Healthcare.gov consumers. Not having these standards apply may lead to consumer confusion and dilution of consumer goodwill with respect to the plans available on HealthCare.gov. The States would conduct QHP certification reviews for these standards.

**PPS COMMENT:** PPS believes all QHP issuers should be required to meet the same “reasonable access” network adequacy standard. It is important to HHS that shoppers at HealthCare.gov do not enroll in plans that fail to meet minimum standards.

#### State Selection of Minimum Network Adequacy Standards

If HHS determines that a State’s network adequacy standard is acceptable, the State would certify to the FFE which plans meet the network adequacy standard, and the FFE in that State would rely on the State’s review for purposes of determining whether a QHP meets the

network adequacy requirements. In States that do not review for network adequacy, or do not select a standard as described above, the FFE would conduct an independent review under a Federal default standard which is proposed to be a time and distance standard. For the certification cycle for plan years beginning in 2017, CMS envisions evaluating the QHP issuer networks under this standard based on the numbers and types of providers, in addition to their general geographic location. In particular, the Agency proposes to calculate a time and distance standard at the county level.

**PPS COMMENT:** PPS believes these proposed standards are appropriate and we support the stated CMS intent to establish a minimum network adequacy floor consistent with the levels generally maintained in the market today. The Federal default standard would provide issuers with more transparency regarding certification processes and will be designed and implemented to achieve results similar to those yielded by the reviews conducted by the FFEs in prior certification cycles.

CMS proposes to require QHP issuers in all FFEs to notify enrollees about a discontinuation in their network coverage of a contracted provider. The Agency proposes that a discontinued provider includes cases of where the provider is being removed and where the provider is leaving the network. You solicit comments on this proposed provision, including the timeframe for notification and on an appropriate definition of “regular basis.”

CMS wonders whether we should define ‘regular basis’ to mean if the enrollee has seen the provider within the last 3 months, 6 months or 12 months. To satisfy this requirement,

CMS expects the QHP to try to work with the provider to obtain the list of affected patients or to use their claims data system to identify enrollees who see the affected providers.

**PPS COMMENT:** PPS joins CMS in the belief that it is important for enrollees to be notified of changes to the network on a timely basis. Consumers need accurate information about which providers are in-network to ensure that they can optimize their health insurance coverage and make cost effective choices. In addition, to the degree possible, PPS would urge the Agency to incorporate an element of quality associated with the various providers that would enable patients to exercise informed choice on that parameter as well as on distance/time traveled and cost. In physical therapy, the metrics associated with quality include functional outcomes measures, data submitted in compliance with Functional Limitation Reporting Requirement (under Medicare) and data reported in compliance with the Physician Quality Reporting System (PQRS). PPS is willing to work with CMS in identifying ways by which these data can be made available to consumers to enhance their ability to make an informed choice.

PPS urges CMS to define ‘regular basis’ to mean if the enrollee has seen the provider within the last 12 months.

PPS notes and supports that the CMS proposal is not intended to preempt any State laws that would be more consumer protective than the federal proposal.

In the proposed rule, CMS notes that certain States measure network adequacy based on enrollee wait times for scheduled appointments. In physical therapy treatment for

an acute injury, early intervention is of considerable importance. For this reason PPS urges CMS to adopt a wait time standard in the form of a broad wait time standard across QHPs in the FFEs.

Moreover, we urge CMS to require QHPs to survey all of its contracted providers on a regular basis to determine if a sufficient number of network providers are accepting new patients, and if not, a timeframe within which the network expansion will take place.

CMS invites comments on transparency of a QHP's standards for selecting and tiering of participating providers for health plan in an FFE and whether issuers should be required to make available their selecting and tiering criteria for review and approval by HHS and the State upon request. You also solicit comments on whether these provisions should apply to all QHPs or only QHPs in the FFEs.

**PPS COMMENT:** PPS applauds the Agency for its proposal intended to accomplish disclosure of a QHP's standards for selecting and tiering of participating providers and urge CMS to require QHPs to make these standards and criteria available for review and approval by HHS and the State upon request. Moreover, we strongly support applying these provisions to all QHPs.

CMS contemplates establishing a rating of each QHP's relative network coverage. This rating or classification could be made available to a consumer when making a plan selection with the intent of helping enrollees select the plan that best meets their needs. In addition, this analysis would compare the breadth of the QHP network at the plan level as compared to the breadth of the other plan networks for plans available in the same geographic area. Then the Agency would analyze the QHP network by calculating the number of specific providers that are accessible within specified time and distance standards. This would result in a classification of the QHP networks into three categories. Such calculation would be based on the provider information submitted by all QHPs issuers in the existing network adequacy FFE QHP certification template, but comments on potential additional data collections are welcome.

**PPS COMMENT:** PPS believes such a rating or classification could be helpful if it is made available to consumers during the plan selection process. The true determination of the utility of such an endeavor would be if the consumer finds it more useful than information that describes in detail the names of providers included in the network.

#### **NETWORK ADEQUACY PRINCIPLES SUPPORTED BY PPS**

To ensure the adequacy of provider networks created and maintained by QHPs, PPS believes in the following principles:

*A QHP recognizing or offering a network shall be required to maintain a network that is sufficient in numbers and appropriate types of providers, to ensure that all covered services to covered persons will be accessible without unreasonable travel or delay.*

*Particular attention should be given to network sufficiency, marketing and disclosure in certain QHP network plan designs, such as tiered, multi-tiered, layered or multi-level network plans, which include different access to benefits and cost-sharing based on a covered person's choice of provider .*

*Network sufficiency shall be determined in accordance with reasonable criteria, which should include, but not be limited to:*

- *provider-covered person ratios by specialty;*
- *geographic accessibility of providers;*
- *geographic variation and population dispersion;*
- *waiting times for an appointment with participating providers;*
- *the ability of the network to meet the needs of covered persons;*
- *other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and*
- *the extent to which participating providers are accepting new patients,*

*A QHP must:*

- *ensure that a covered person obtains the covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider;*
- *document all requests to obtain a covered benefit from a non-participating provider and shall provide this information upon request;*
- *establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address;*
- *monitor, on an ongoing basis, the ability and clinical capacity of its participating providers to furnish all contracted covered benefits to covered persons;*
- *maintain, and inform covered persons of, the plan's grievance and appeals procedures;*
- *maintain updated provider directories for each of its network plans;*
- *notify the beneficiary of any contract termination in a timely manner;*
- *maintain and make available its plan for providing continuity of care in the event of contract termination between the QHP and any of its participating providers;*
- *establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including an limitations or conditions on services;*
- *not discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license under applicable state law or regulations;*
- *make its standards for selecting and tiering, if applicable, participating providers available in plain English to the public;*

- *not offer any inducement to a provider that would encourage or otherwise incentivize the provider to deliver less than medically necessary services to a covered person;*
- *not prohibit a participating provider from discussing any treatment options with covered persons irrespective of the QHP's position on the treatment options;*
- *not prohibit a participating provider from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the QHP or any related entity;*
- *establish and maintain procedures for resolution of administrative, payment or other disputes between providers and the QHP.*

*A QHP and a participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause. When a covered person's provider leaves or is removed from the network, a QHP shall transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.*

*A QHP must notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.*

*A QHP must not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the QHP that jeopardizes patient health or welfare.*

### *Provider Directories*

*QHPs should be required to post electronically a current and accurate provider directory for each of its network plans. Moreover, in making the directory available electronically, the QHP shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number. And the QHP shall update each network plan provider directory at least monthly.*

*The QHP shall make available through an electronic provider directory, for each network plan, the following health care professional information in a searchable format:*

- *name*
- *gender;*
- *participating office location(s);*

- *specialty, if applicable;*
- *languages spoken other than English, if applicable; and*
- *whether accepting new patients.*

In the proposed rule, CMS puts forth the following with respect to:

Provider transitions.

A QHP issuer in a FFE must—

- (1) Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;
- (2) In cases where a provider is terminated without cause, allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

“Active treatment” includes treatment for a serious acute condition; an ongoing course of treatment for a health condition for which a treating health care professional attests that discontinuing care by that clinician would worsen the condition or interfere with anticipated outcomes.

**PPS COMMENT:** PPS is in agreement with and supports the above standards including “provider transitions” and the definition of “active treatment.” Moreover, we believe any decisions made for a request for continuity of care must be subject to the health benefit plan’s internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

**COST-SHARING REQUIREMENTS**

In the proposed rule, CMS puts forth the following with respect to certain provisions related to cost-sharing requirements:

Out-of-network cost sharing. For a network to be deemed adequate, each QHP that uses a provider network must:

- (1) Count the cost-sharing paid by an enrollee for an essential health benefit provided by an out-of-network provider in an in-network setting towards the enrollee’s annual limitation on cost sharing; or
- (2) Provide a written notice to the enrollee at least ten business days before the provision of the benefit that additional costs may be incurred for an essential health benefit provided by an out-of-network provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

CMS also proposes a number of incremental amendments intended to improve the choices available to consumers and supporting consumers’ ability to make informed choices when

purchasing health insurance. The Agency proposes a standardized option with a specified cost-sharing structure at each of the bronze, silver (with cost-sharing reduction (CSR) plan variations), and gold metal levels.

**PPS COMMENT:** In the proposed rule, CMS expresses its belief that *“transparency is critical to informed decision-making, and this proposed rule includes several proposals to increase transparency.”* PPS supports the patient’s ability to make informed choices not only when purchasing health insurance but using it as well. In other words, PPS urges CMS to consistently formulate policy that consistently fortifies the patient’s ability to be an informed consumer of health care services, including choice of provider.

The Agency proposes that the premium adjustment percentage for 2017, which is used to set the rate of increase for several parameters detailed in the ACA, include the maximum annual limitation on cost sharing for 2017 for cost-sharing reduction plan variations. CMS stresses the intent to ensure Americans have access to not only affordable, but also robust, high-quality health care coverage.

**PPS COMMENT:** PPS urges CMS to take the necessary steps in regulation to prohibit QHPs from employing steep cost-sharing practices (primarily copayments and arbitrary deductibles), whether in-network or out-of-network as means of controlling utilization with respect to physical therapy. By requiring large provider specific deductibles and copays on a per-visit basis, patients are dissuaded from receiving the physical therapy necessary to achieve the functional improvement goals (outcomes) of the designed treatment plan. By its very nature, physical therapy treatment nearly always involves a series of treatment visits, each building on the foundation and progress of the preceding. Not only should CMS prohibit inordinately large copays, but should require QHPs (in FFEs and broadly) to apply copays for rehabilitation therapy on an episode of care basis as opposed to a per-visit basis.

### **SMALL BUSINESS HEALTH OPTIONS PROGRAM**

CMS proposes a new “vertical choice” model for Federally-facilitated Small Business Health Options Program (SHOP) plans beginning on or after January 1, 2017, under which employers would be able to offer qualified employees a choice of all plans across all available levels of coverage from a single issuer.

**PPS COMMENT:** **Since our** members own and operate small business, PPS supports the CMS proposal to create a new “vertical choice” model for Federally-facilitated SHOP plans under which employers would be able to offer qualified employees a choice of all plans across all available levels of coverage from a single issuer. This is important proposal would represent a significant step toward effecting choice for employees of small businesses.

### **DEFINITIONS OF SMALL AND LARGE EMPLOYER**

CMS proposes revisions to the definitions of small employer and large employer to bring them into conformance with recently enacted legislation.

**PPS COMMENT:** PPS agrees with the proposed revisions to the definitions of small employer and large employer to bring them into conformance with recently enacted legislation.

PPS thanks CMS for the opportunity to provide these comments on CMS-9937-P the proposed rule for the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017. As small businesses, providers, and employers, PPS members are committed to implementation of meaningful and effective health care reform and we pledge to continue our cooperation and collaboration with CMS.

Sincerely,

A handwritten signature in black ink that reads "Terrence C. Brown". The signature is written in a cursive style with a long horizontal line extending from the end of the name.

Terrence Brown, PT, DPT  
President, Private Practice Section of APTA